Health Care Financing Administration

Forum

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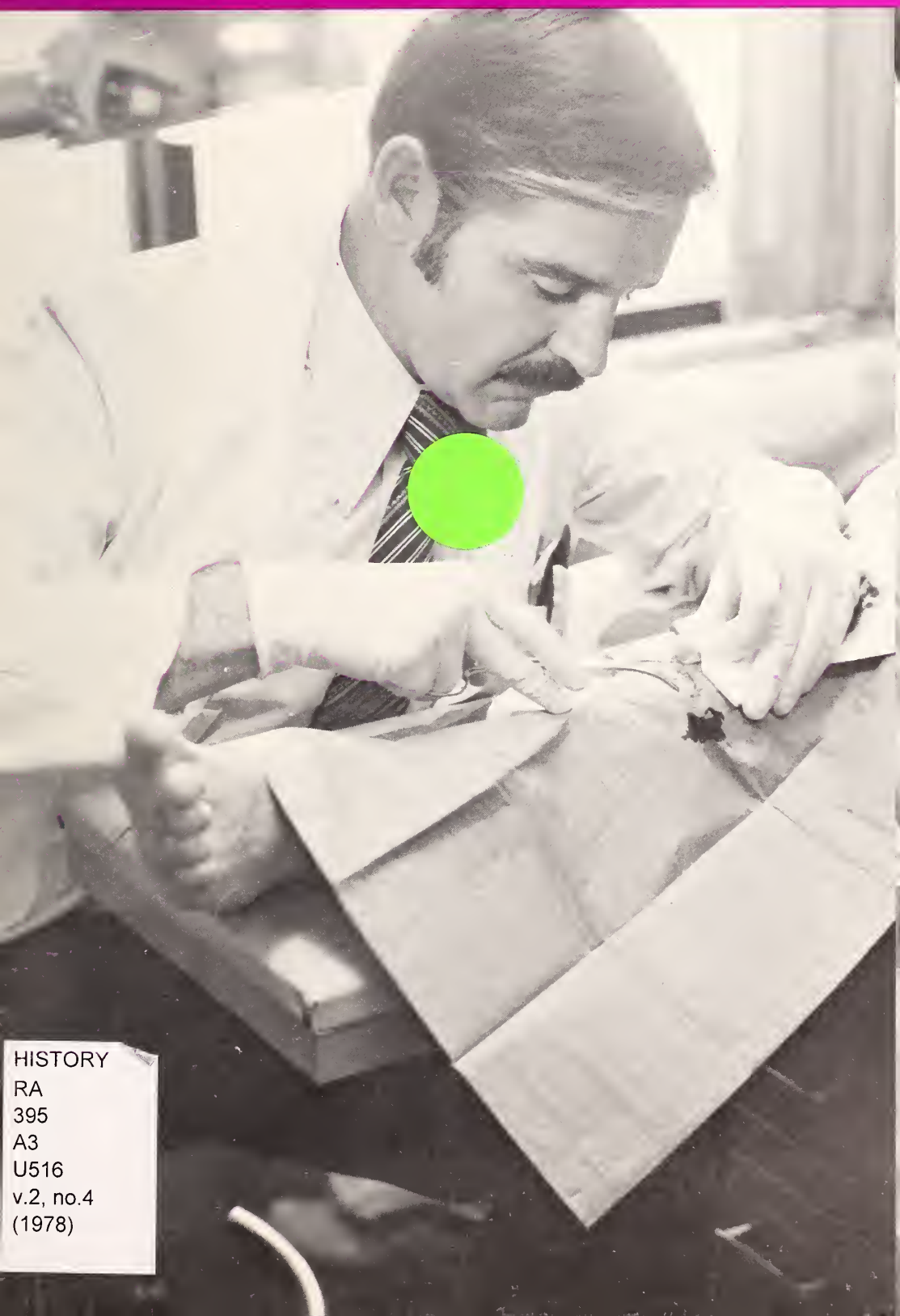
Physician Assistants Achieve Wide Acceptance.

Trends in Employer Health Insurance May Stem Rising Costs.

Fraud Control Units Gear Up.



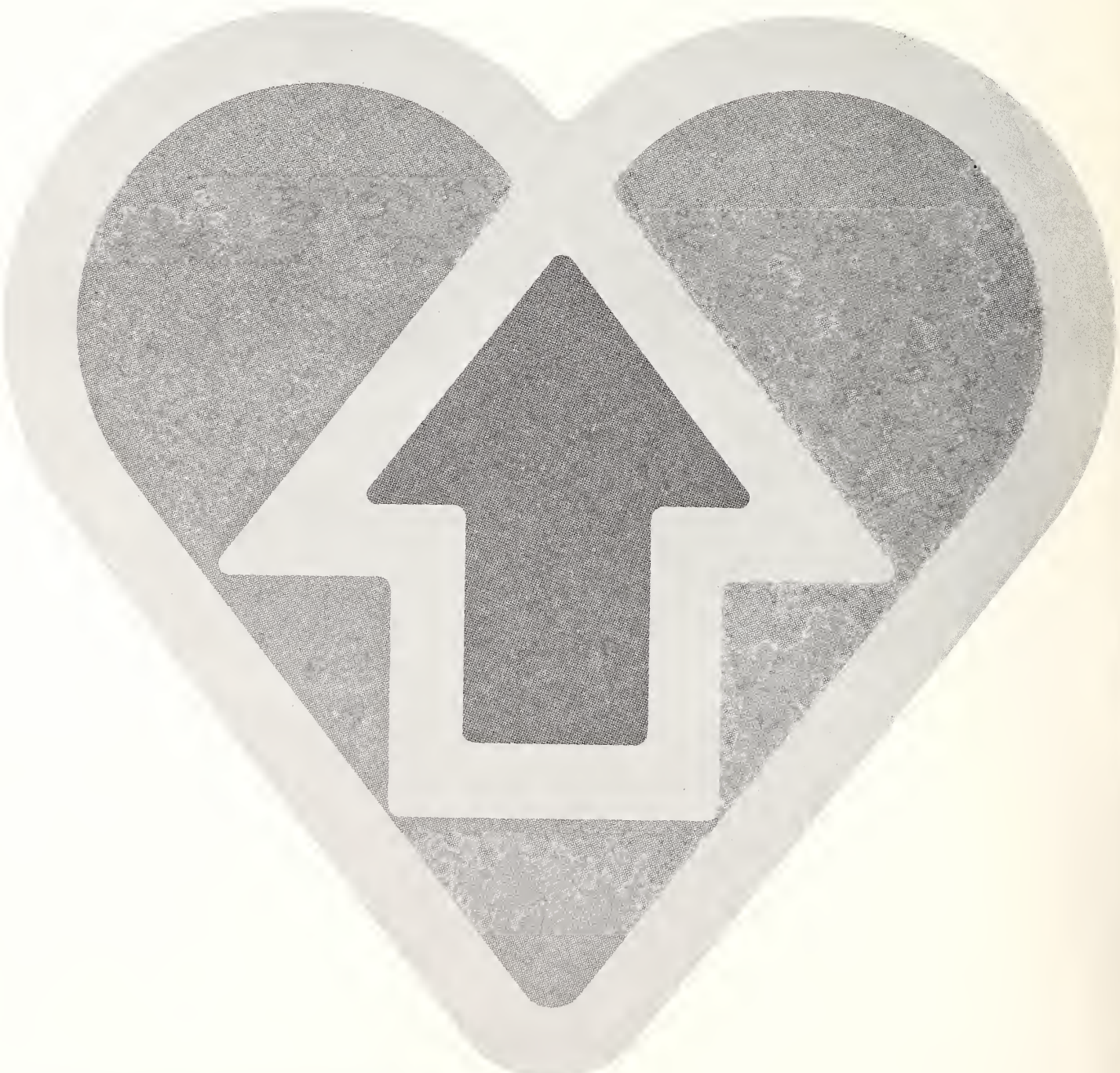
Don't Let The Silent Killer Silence You.

It's called the silent killer because it usually has no symptoms. You might not even know you have it. But high blood pressure can lead to stroke, heart failure, and kidney disease.

There isn't any cure for high blood pressure. Not yet, anyway. But it can nearly always be controlled, and if you have it, you can live a normal, healthy life.

Get a blood pressure check for yourself and every member of your family. Even the kids. If your blood pressure is high, see a doctor—and follow his advice.

Don't let the silent killer silence you.



Forum

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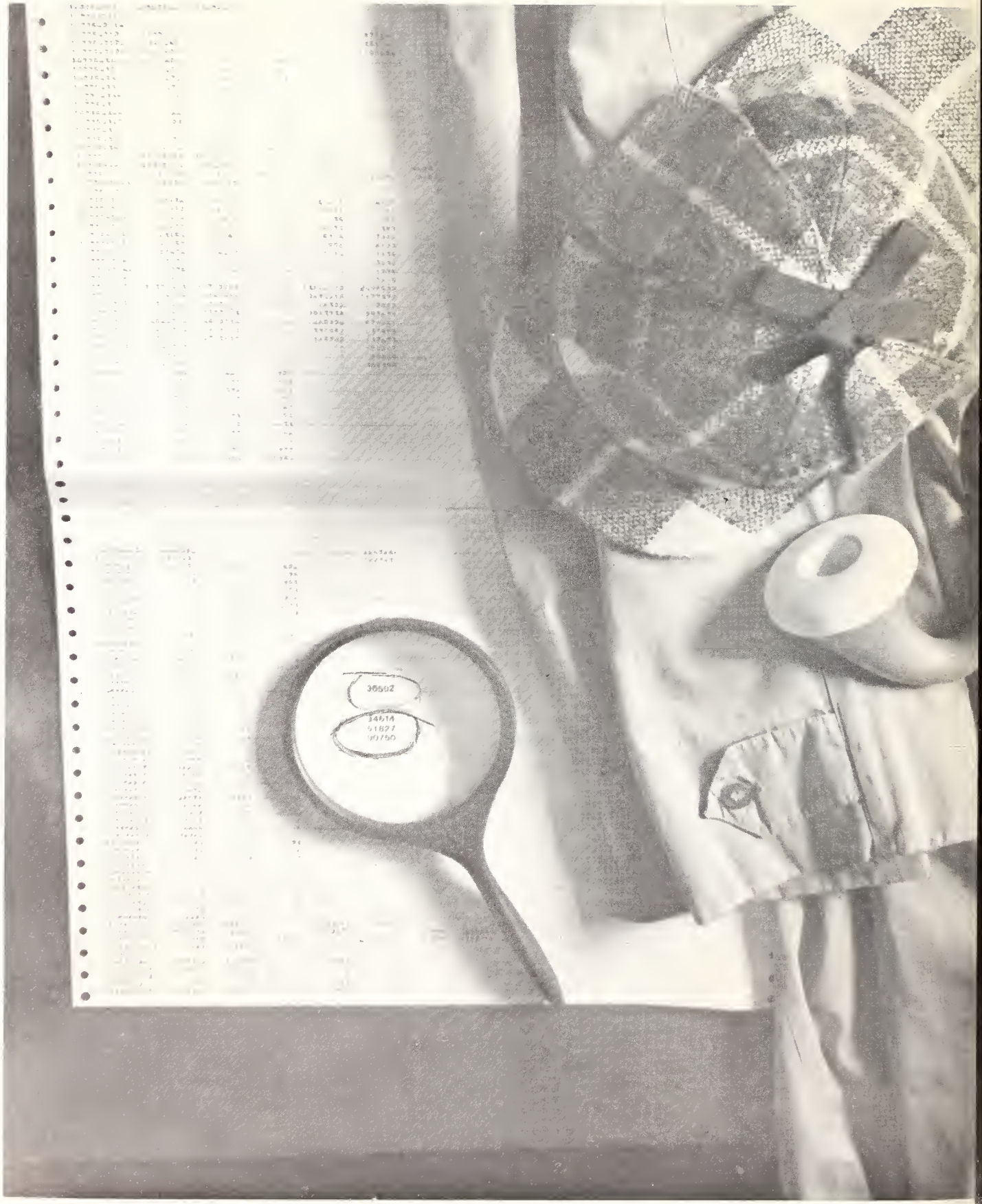
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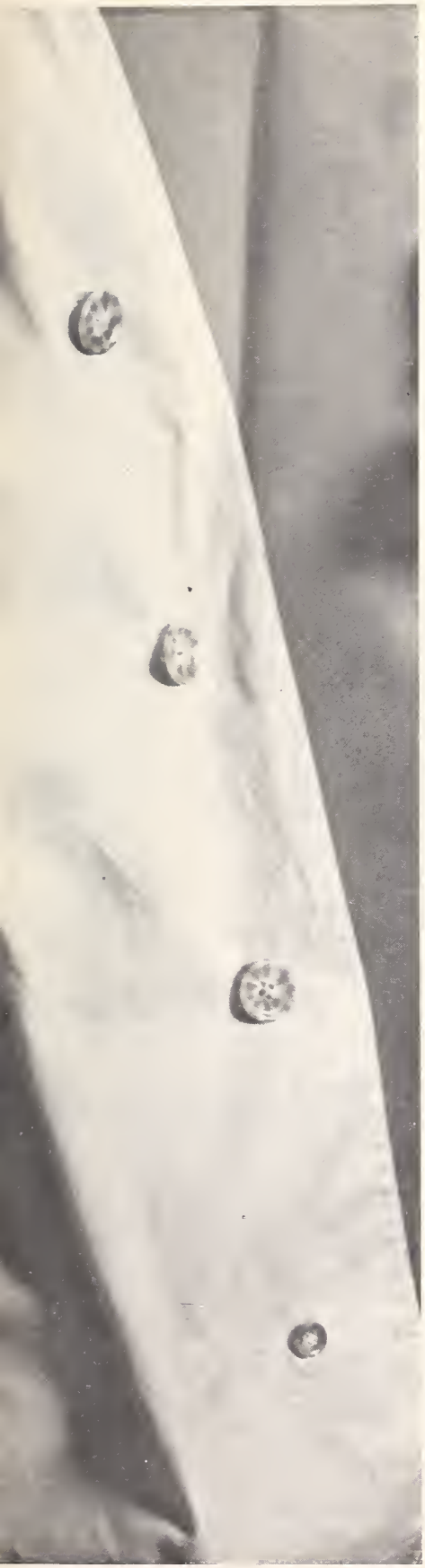

Fraud Control Units Gear Up To Detect Illegal Billings and Prosecute Offenders.

by Ann Slayton

Since the scandals of Medicaid Mills splashed across the country's newspapers and television screens in 1976, there has been an increased effort to curb fraud and abuse in both the Medicaid and Medicare programs.

The best estimates of federal and state funds lost annually to fraud and abuse in the two programs is $15 million for Medicare and $653 million for Medicaid. But so-called administrative waste and errors bring the total loss to $4.5 billion annually.

Officials have been understandably reluctant to make firm predictions about how much this loss will be cut once the anti-fraud, abuse and error campaigns are fully mobilized. One reasonable estimate for fraud and abuse is that for every dollar spent in reviews, investigations, and prosecutions, between 4 and 5 dollars will be recovered.

Between April 1975 and March 1978, the State of New York spent $12.4 million to ferret out fraud involving $113 million. Of this, the state expects to recover at least $65 million. What cannot be measured, however, is the deterrent value of these well publicized convictions.

Nationally, during Fiscal Year 1977 the states reported that they referred 391 cases of suspected fraud to law enforcement officials for prosecution. Of these, 91 convictions were obtained, and an additional 149 providers were barred from participating in the Medicaid program. The total amount of payments for fraudulent claims in those cases was nearly $70 million.

HEW has been reviewing the claims of 26,000 physicians and pharmacists whose patterns of utilization and reimbursement appear to be improper when compared to established norms. To date some 600 of those have been referred for full-scale investigation. Thus far, 16 indictments have been returned, and there have been six convictions and one acquittal.

Don Nicholson, director of HCFA's Office of Program Integrity, is quick to point out that prosecutions are not sought on these data alone. "These data are useful only insofar as they provide an indication of potential fraud or overutilization," says Nicholson. A decision to prosecute for fraud cannot be made until a thorough investigation has been completed; this would include an examination of medical records to determine the type of services actually rendered.

While incidents of fraud and efforts to combat it have captured most of the headlines, work also has been underway to reduce administrative waste and error. Goals were set for states to reduce eligibility errors. States that achieved these goals would continue to receive their full share of federal funds; States that did not would lose a measure of funds.

Before the Medicare-Medicaid Anti-Fraud Amendments were passed in October of 1977, each state Medicaid agency was responsible for detecting, investigating, and developing suspected cases of fraud. There were great variations in the states' capabilities to control fraud. Some had no programs of control at all, and a few, like New York, Texas, California and New Jersey, had programs which had been in operation for several years.

To attack the problem across a broad front, Congress established the office of Inspector General in HEW to coordinate the total program, and

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HCFA established the Office of Program Integrity. The combined effort took three major approaches:

- Increasing the number of field investigators
- Assisting the states to more effectively develop cases of Medicaid fraud, particularly provider fraud
- Developing management and reporting systems which would help them identify errors and overpayments

Before May 1975, Medicaid had 32 program personnel involved in fraud and abuse and HEW had 10 professional investigators. Today, HCFA has 280 program integrity specialists around the country and the Office of Inspector General has about 65 professional investigators, with another 70 authorized. States whose fraud control units are certified have added a total of 690 investigators, lawyers and auditors. In the effort to counteract fraud, the Government pays 90 percent of the costs of these state operations.

Training

HEW has conducted training programs for its own staff since 1969. Now the responsibility is shared by the Institute of Medicaid Management, the Inspector General's Office of Investigation, and HCFA's Office of Program Integrity. Training is given in investigative techniques, legal grounds for prosecution, and developing a case for prosecution.

First, a general introduction to the Medicaid and Medicare programs is given so that investigators will know how to question providers effectively and how to locate and quickly check records for irregularities.

Second, trainees are given an introduction to criminal law, including an explanation of statutes pertaining to mail fraud, false statements and claims, embezzlement and theft, perjury, conflict of interest, bribery, and graft by Government employees.

The third stage of the program concerns gathering evidence. Investigators and auditors learn what constitutes evidence, what evidence is admissible in court and the correct procedures used to obtain evidence.

State fraud control units

To some extent, the present effort to curb Medicaid fraud is not a continuation of the old game, but a different game altogether. During the period when the states each ran their own fraud control activities—or didn't—the game was much like a casual summer afternoon drive. Now, not only has the pace of the drive picked up, but the drivers are more skilled and are driving high-performance cars.

A state fraud control unit is composed of investigators, attorneys, auditors and other specialists whose combined skills create a vigorous team. The units are viewed by the Congress as vitally needed to restore public confidence in the Medicaid program and to deter providers from committing fraud.

HEW pays 90 percent of the cost of these units for up to three years. After this period, the states are expected to support their own operations.

To date 16 states have received certification for their units, and an equal number have expressed a strong interest in establishing units. The three general requirements for states to receive funding of their anti-fraud units are:

- The unit must be "separate and distinct" from the state Medicaid agency.
- The unit must be located either within the office of the state attorney general, or with an agency that has statewide prosecution authority or within an agency with a formal working relation with the state attorney general, approved by HEW.
- All procedures must be developed and memoranda of understanding written, and the applicant must show that there is sufficient staff to properly investigate, prepare, and prosecute suspected fraud cases.

The capability for prosecution and a thorough grounding in Medicaid are considered the cornerstones for a successful fraud control program.

One barrier to certification is that in several states, the attorney general does not have statewide prosecution authority. To gain certification, some states are seeking legislation to give them the necessary authority. Other states may be able to show that they already have effective procedures for referring cases of suspected fraud to all appropriate prosecuting authorities.

The fraud control unit must have a combination of investigators, attorneys, and auditors on a full-time basis. It must also employ or have access to other professionals knowledgeable in medicine, pharmacy, and the Medicaid requirements under Title XIX.

The fraud unit and the Medicaid agency must have a written agreement which covers the procedures for referring cases of suspected fraud to the unit, a guarantee of access to Medicaid files, and assurance of confidentiality.

In addition to handling all aspects of abuse, the Medicaid agency continues to review suspected provider fraud. Those cases which are questionable are referred to the fraud unit for investigation.

In a case where it is clear that providers have received funds to which they are not entitled, the fraud unit will ask for restitution, or refer it back to the state agency for recovery. In either event, the fraud unit follows the case closely to see that some action is taken quickly.

Obviously, good working relations and good communication between the Medicaid agency and the fraud control unit are essential. New Jersey has had its fraud control unit housed within the attorney general's office for more than three years. Referral and administrative guidelines were worked out between the state Medicaid agency and the attorney general's fraud unit in 1977.

Before the two offices established guidelines for the timely processing of cases, the cases "would sit in the Medicaid agency for years," says Robert Sturges, chief of the attorney general's fraud unit. Now the average turn-around time is 30 days.

During this 30-day period a case is

referred to the fraud unit for review and is either prepared for investigation and prosecution or sent back to the Medicaid agency for administrative disposition.

Administrative sanctions include suspension of the suspected provider while the fraud unit is preparing a case for prosecution. Respresentatives of the two offices meet twice a month to inform each other of progress in each case.

Evaluating success

The anti-fraud approaches of states vary considerably. Oklahoma, for example, has long emphasized prevention through good relations with the provider community and through tight program management. The state conducts a training program for providers, closely screens and verifies all claims, and widely publicizes its convictions of fraud. Montana also has a rigorous claims screening process and reports a low number of prosecutions. In these two cases, dollar recoveries have little meaning in assessing the programs' successes.

How, then, is a state's fraud control activity assessed? Says Don Nicholson, director of the Office of Program Integrity, "Our evaluation of a state's efforts is determined by a variety of factors: the state's commitment of resources to fraud and abuse control; its workload, including investigations, convictions, sanctions, and prosecutions; its demonstrable efforts to improve operations; and the basic characteristics of its program."

How is the success of states' efforts measured in national terms? The picture is incomplete because, until now, states have not been required to systematically report data on prosecutions, overpayments, or recoveries.

The Office of Program Integrity has established uniform reporting requirements, which will produce a continuous flow of information from the states. These reports will help HCFA construct a national picture of both the problems and the progress in controlling fraud and abuse.

The status of each case being prepared for prosecution is monitored by HCFA, including where the case was referred for prosecution and its final disposition.

Each year state fraud units must report the number of:

- Investigations initiated, completed and closed
- Cases prosecuted or referred for prosecution and the outcomes
- Complaints received on abuse and neglect of patients in health care facilities, and the number investigated or referred
- Recovery actions initiated by the unit and the Medicaid agency, and the total dollar amounts recovered

Management and data systems

In 1977 it was estimated that eligibility and payment errors by state Medicaid agencies were responsible for some $600 million misspent federal dollars, and that perhaps 20 percent of Medicaid recipients were ineligible for assistance.

In an effort to disseminate to all states the most successful error-reduction techniques developed in any one state, the Institute for Medicaid Management was established. The institute's claims processing and information retrieval system is designed to eliminate errors and to spot patterns of billings that may be improper.

To date 17 states have installed this system and are receiving 75 percent federal funding for operating them. HCFA also pays the states 90 percent of the cost to develop the system. Recently, the system developed by the State of Indiana was adopted by Alabama, thus saving more than $3 million in the cost of designing and implementing a new system. The system was slightly modified and became operational in 9 months for a total cost of $500,000. This is a typical example of the savings that can be achieved by sharing.

Another new computer program intended for eventual installation in the states is the Medicaid Exception Reporting System. It checks for excesses in:

- Encounters between single patients and providers
- Encounters between patients and multiple providers
- Number of services provided
- Number of certain types of diagnoses

The first application of the Exception Reporting System in New Jersey identified 50 providers for investigation. Of the 50 only 17 had been selected by state Medicaid personnel for review.

A quality control program was launched in the states to ensure that only persons eligible for benefits receive them. An analysis showed that about 20 percent of the persons on the Medicaid roles were not eligible.

HCFA is proposing a regulation to help states set goals for reducing errors. The regulation, which is expected to become effective by the end of this year, requires states to set goals for reducing error levels at the median of their current error rate or, if set above the median, reduce the error rate by at least 18 percent by October 1, 1979.

The reduction of unnecessary payments due to ineligibility, claims processing errors and the uncollected liabilities of other parties, such as insurance companies, is expected to save $272 million by October 1, 1979. By October 1, 1980, the projected saving is $266 million, and by 1981 $259 million.

Secretary Califano has said, "This department has no more challenging or important task than instilling confidence in the American taxpayer that the vast sums expended by HEW each year are managed with fiscal integrity and responsibility."

The state fraud control units are vital to the issues of curbing fraud by providers and reinstating fiscal integrity to the Medicaid program. By the beginning of 1979, it is anticipated that a majority of the states will have units in full operation. The data uniformly reported to HCFA by the units together with data from the new management systems now being installed in state Medicaid agencies will bring into focus, for the first time, a clear and complete picture of the progress toward curbing fraud and abuse. ■

Physician Assistants Achieve Wide Acceptance in Health Care Field.

by Dr. Donald Fisher and William Stanhope

Within a decade the concept of the physician assistant in the United States has been transformed from an academic theory into a smoothly operating, practical reality.

The objective of the physician assistant program is to have specially trained persons assume some responsibilities previously reserved for physicians. The concept is a radical departure from all other concepts of health care professionals because physician assistants would be responsible for a broad spectrum of activities across the entire medical problem-solving process: intake, data gathering, diagnosis, and developing therapeutic plans and special treatments.

A second departure from tradition is that, rather than being trained to function independently in one or two areas of medical problem-solving, physician assistants are trained to work autonomously under the supervision of a physician.

This new approach has come to be recognized as one of the most significant innovations in health care delivery in the past several decades. Since the health care system is extremely labor intensive, the physician assistant offers a tremendous potential for containing costs through a division of the physician's labor.

Dr. Donald Fisher is executive director of the Association of Physician Assistant Programs and the American Academy of Physician Assistants and holds a doctorate in anatomy. William Stanhope, the founding president of the American Academy of Physician Assistants, is an associate professor at the University of Oklahoma's Department of Family Practice. He is currently on sabbatical leave, serving as a Robert Wood Johnson Foundation Health Policy Fellow at the National Academy of Sciences' Institutes of Medicine.

Cost savings

Although concerns about health care costs lacked current buzz-word status when the physician assistant concept was originally developed, it is clear that the physician assistant profession holds tremendous potential for a very significant savings in both production and delivery costs.

The cost to train a physician assistant is less than one-fourth the cost of training a physician. Several studies have shown that the output of the physician assistant approximates the output of the physician in primary care settings. A recent study by the Kaiser Research Foundation shows that, in primary care settings, a prepaid program of health care can save in excess of $20,000 a year for each physician assistant in an optimum mix of physicians and physician assistants.

The optimum ratio of physician assistants to physicians in institutionally based specialities is yet to be determined. But a recent study, using specially trained physician assistants in diagnostic radiology, shows encouraging results, although the study does not address cost savings.

To date 45 states have passed legislation codifying the physician assistant occupation. A majority of the legislation specifically recognized that a physician can delegate medical tasks to a physician assistant whom he supervises. In a majority of states with such legislation, the regulatory authority for physician assistants is vested with the state board of medical examiners.

One of the original goals of the physician assistant concept was to augment the scarce supply of physicians in rural, underserved areas. A number of programs report that large percentages of their graduates are being placed in underserved areas. Examples of successful rural distribution are provided by the Utah, Oklahoma, and Washington programs which show respectively 72 percent, 62 percent, and 58 percent of their graduates in communities of fewer than 25,000. A recent survey of the membership of the American Academy of Physician Assistants shows that 50 percent of those surveyed are in communities of fewer than 50,000.

The survey also asked about the types of care provided by physician assistants and the speciality of the supervising physician. Results of this query are shown in the accompanying tables. Physician assistants are currently employed in all areas of medicine, primary care and the subspecialities, private practice, prepaid programs, and in federal and state institutions. The specific responsibilities of physician assistants in primary care were developed by the American Academy of Physician Assistants, under contract with HEW.

Recent changes in national policy directed at foreign medical graduates, as well as changes in the number of approved residencies and positions within existing subspeciality residencies, are creating demands for physician assistants to function in roles previously filled by house staff. Dr. Richard Rosen of the Department of Surgery at Montefiore Hospital and Medical Center in New York has pioneered in this area and reports considerable success in substituting

Typical Physician Assistant Courses for First Year

Classroom Hours of Instruction	Course
16	Medical Terminolgy
16	Biochemistry (Program Text)
175	Clinical Anatomy
81	Behavior Dynamics I
81	Behavior Dynamics II**
82	Behavior Dynamics III
220	Etiology & Pathogenesis of Diseases**
68	Gross Pathology
71	Physical Diagnosis
80	Clinical Medicine I
80	Clinical Medicine II
32	Introduction to Electrocardiography
189	Laboratory Med. & Clin. Proceedings **
37	Laboratory Med. & Clin. Proceedings II
24	Obstetrics and Gynecology
180	Applied Physiology *
28	Pediatrics I
30	Pediatrics II
20	Clin. Nutr. for Health Prof.
30	Human Values in Primary Care
16	Human Sexuality
39	Emergency Medicine
10	Dermatology Seminars
48	Introduction to Pharmacology
60	Introduction to Radiology
28	Intro. to Health Care Services
22	Director's Hour
1763	**Total Hours**

** Sophomore Medical School Course
* Freshman Medical School Course

physician assistants for surgical house staff.

Early skepticism

Many early skeptics of the physician assistant concept felt they would significantly increase the supervising physician's risk of malpractice suits. This argument was based on two premises, both of which have been proven invalid by several broad-based studies.

First, it was thought the quality of care would suffer. Since 1968, when the first formally trained physician assistant entered the job market, there have been no judgments awarded for malpractice involving physician assistants. B. J. Anderson of the American Medical Association's legal staff says that as a result of decreased waiting time, increased accessibility to professional care and overall patient satisfaction, it appears that the inclusion of a physician assistant in a practice is an excellent deterrent to the ever present threat of malpractice. All studies to date, of which these writers are aware, have shown that the quality of services delivered by physician assistants is comparable to that delivered by physicians.

Second, many skeptics claimed that patients would never accept medical services from anyone other than a physician. Numerous studies have shown that not to be the case. In fact, both statistical and anecdotal data have shown that many patients are much more comfortable with physician assistants than with physicians, because of the perceived difference in social class between patient and physician.

Many of these uncertainties were fueled by the early writings of persons who, while well-intentioned, were writing from a hypothetical posture rather than from a base of experience with physician assistants. These writings added greatly to the confusion and ambivalence surrounding the evolution of physician assistants.

Training program

In 1965 Duke University's Department of Medicine established the first formal training program for physician assistants in the United States. The Duke program was quickly emulated by other universities and there are currently 55 programs accredited by the Council on Allied Health Education and Accreditation.

Competition for seats in the 55 physician assistant programs is keen. For example, in 1977 the University of Oklahoma had eight candidates for each opening. The typical physician assistant graduating in 1975 was between 24 and 31 years old, had 2 or more years of prior experience in an allied health discipline and had 2 or more years of college-level education before entering the physician assistant program.

The average physician assistant program accredited by the council is 24 months long. Basic and clinical science information is presented during the first year of the program (see accompanying table). In the second year, physician assistants spend 6 weeks of training in each of the following: general surgery, internal medicine, emergency medicine, and 12 weeks of training in primary care. In addition, they must serve 6-week preceptorships in two of the following four services: obstetrics, pediatrics, cardiology, or orthopedics.

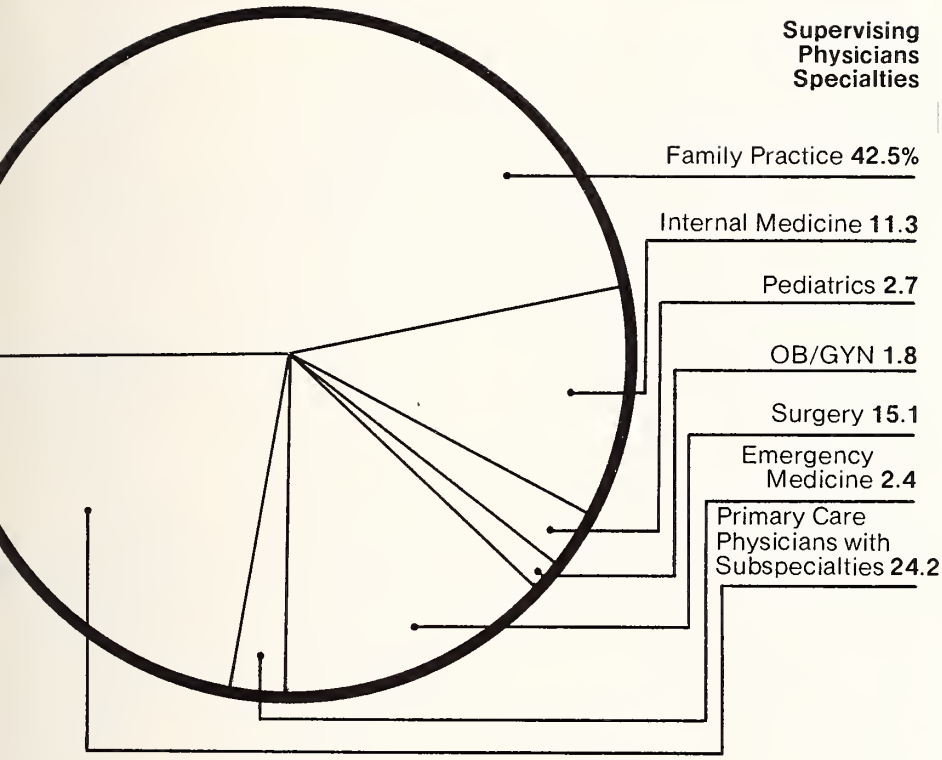
Curriculums vary, but a fairly typical one is the University of Oklahoma Physician's Associates Program which requires 1,763 classroom hours of preclinical instruction, roughly the equivalent of 108 semester hours.

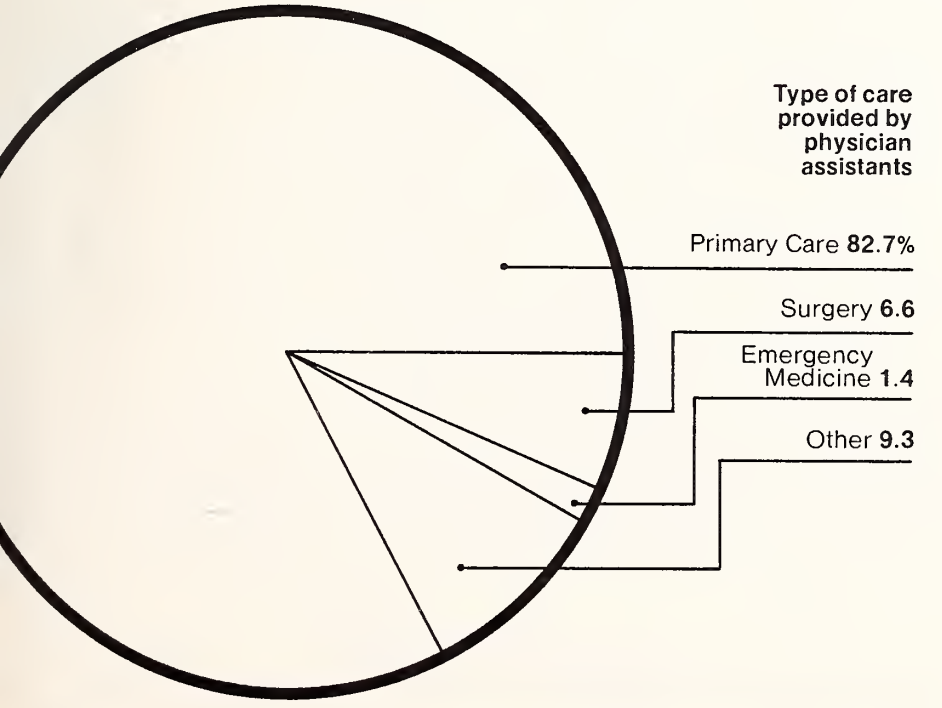
The courses are listed in an accompanying table, but two areas of the curriculum are of particular interest.

Physician assistant students are required to take four courses which also are required of medical students. They are applied physiology (a freshman-level course), etiology and pathogenesis of disease, laboratory medicine and clinical proceedings, and behavior dynamics, sophmore-level courses.

Data on comparative student performance in the etiology and pathogenesis of disease course have been compiled over several years and show that the mean performance of the physician assistant on examinations was 10 points below that of the medical student, but 10 points above the mean of dental students taking the same course.

Also noteworthy is the fact that the clinical training program at the Uni-





versity of Oklahoma has evolved to emulate the decentralized clinical training model developed at the University of Washington in Seattle. At the University of Oklahoma physician assistant students are required to take nine clinical rotations but only allowed to take three of the nine at traditional teaching hospitals. This model of decentralized clinical training was developed to increase the rural placement of graduates and is judged to be successful by the fact that 62 percent of the graduates have located in communities of fewer than 25,000.

Evaluation of these programs is made by the Joint Review Committee for the Accreditation of Physician Assistant Programs. The committee is composed of members of the American Academy of Pediatrics, the American Academy of Physician Assistants, the American Society of Internal Medicine, the American Academy of Family Practice, the American College of Physicians, and the American College of Surgeons.

Under the auspices of private foundations and the Federal Government an examination was developed to assess the competency of graduate physician assistants. In late 1973 an independent commission was established to assure the competency of this new health professional. The National Commission of Certification of Physician's Assistants comprises those associations that represent the employers of physician assistants.

The examination is given in two parts. First, the written portion tests the candidate's basic clinical knowledge and clinical problem-solving ability through multiple choice and patient management types of questions. Second, candidates are required to demonstrate competency in physical diagnoses by performing an examination under rigid observation.

Test scores are not curved, so students must achieve the standard set by the commission. Because the commission is concerned not only with entry level competency, but also with continuing competency, graduate physician assistants are required to complete 100 hours of postgraduate training every 2 years and to take a recertification examination every 6

years. The first recertification examination will be given in 1981.

On December 13, 1977, amendments to Titles XVIII and XIX of the Social Security Act authorized reimbursements for services provided by physician assistants and nurse practitioners in clinics located in underserved rural areas. There are also provisions in these amendments for experimental reimbursement to underserved urban clinics and practices.

In less than 10 years, the physician assistant has become not only a reality, but a significant contributor to the health care field. It is the intention of the profession to continue to hone its skills in the designated areas of performance in order to become even more effective. ■

Typical Hospital Job Description.

The physician assistant shall be primarily responsible for performing clinical duties, customarily carried out by physicians. These duties are under the supervision, but not necessarily the direct surveillance of the responsible physician. The physician assistant shall function as the direct representative of the physician in all conjoined efforts. Most of the duties will fall into the categories of general medicine, surgery, obstetrics and gynecology, pediatrics, emergency room medicine, and office privileges.

In general, the duties for these six areas shall consist of collecting histories, performing physical examinations, and making other chart entries that must be reviewed by the responsible physician within 24 hours. Orders by the physician assistant will be carried out when written, but must be reviewed and countersigned by the responsible physician as soon as feasible, normally within 24 hours. Any decision to admit or discharge a patient from inpatient or outpatient care shall remain the physician's.

General Medicine

The physician assistant shall perform initial history and physical examinations on new hospital inpatients and outpatients as well as those in extended care facilities. He shall be able to present medical problems to the patients and to the responsible physician, and he shall be able to record the medical data essential to sound treatment and planning.

The physician assistant shall be able to order appropriate laboratory tests, x-rays, ECGs and comparable procedures; he also must be able to draw blood specimens, both venous and arterial, start intravenous solutions, and order routine medications which will be carried out immediately, but countersigned within 24 hours by the responsible physician.

The physician assistant shall be able to initiate consultations and monitor schedules of patients for special tests when so ordered by the responsible physician; he shall make daily rounds to observe the progress of patients, update and summarize charts, as well as change orders when appropriate; he shall notify the responsible physician of changes in the patient's condition, and dictate the required notes on all procedures performed.

The physician assistant shall be able to counsel the patient and his family in preventive care, medical problems, methods of prescribed treatment, and in the use of drugs.

The physician assistant should be able to perform nasogastric and nasotracheal procedures and intubations as well as gastric analysis when ordered by the responsible physician.

Emergency procedures

The physician assistant shall be able to perform the following emergency procedures pending the arrival and availability of a responsible physician:

- Manage cardiac arrest patients, including the use of external cardiac compression, emergency medications—such as, epinephrine, sodium bicarb, atropine, vaso-constructors—and he should be able to initiate electrodefibrillation
- Manage acute respiratory failure patients
- Manage life endangering traumatic injuries
- Pass endo-tracheal tubes
- Order and administer oxygen
- Order and start whole blood

Surgery

The physician assistant shall be able to perform physical evaluations of patients with surgical problems, establish a working diagnosis and then proceed with a general work-up by ordering appropriate laboratory studies; he shall then be able to present the pertinent medical data to the responsible physician.

The physician assistant shall be able to care for wounds and suture lacerations, write both pre- and post-operative orders as specified by the responsible physician and write post-operative progress notes.

Obstetrics and gynecology

The physician assistant shall be able to record the history of and perform the physical examination on any obstetric or gynecology patient, including prenatal examinations; he shall be able to assist the physician during complicated deliveries and normal deliveries, and institute proper medical treatment for gynecological problems after first presenting these problems to the responsible physician.

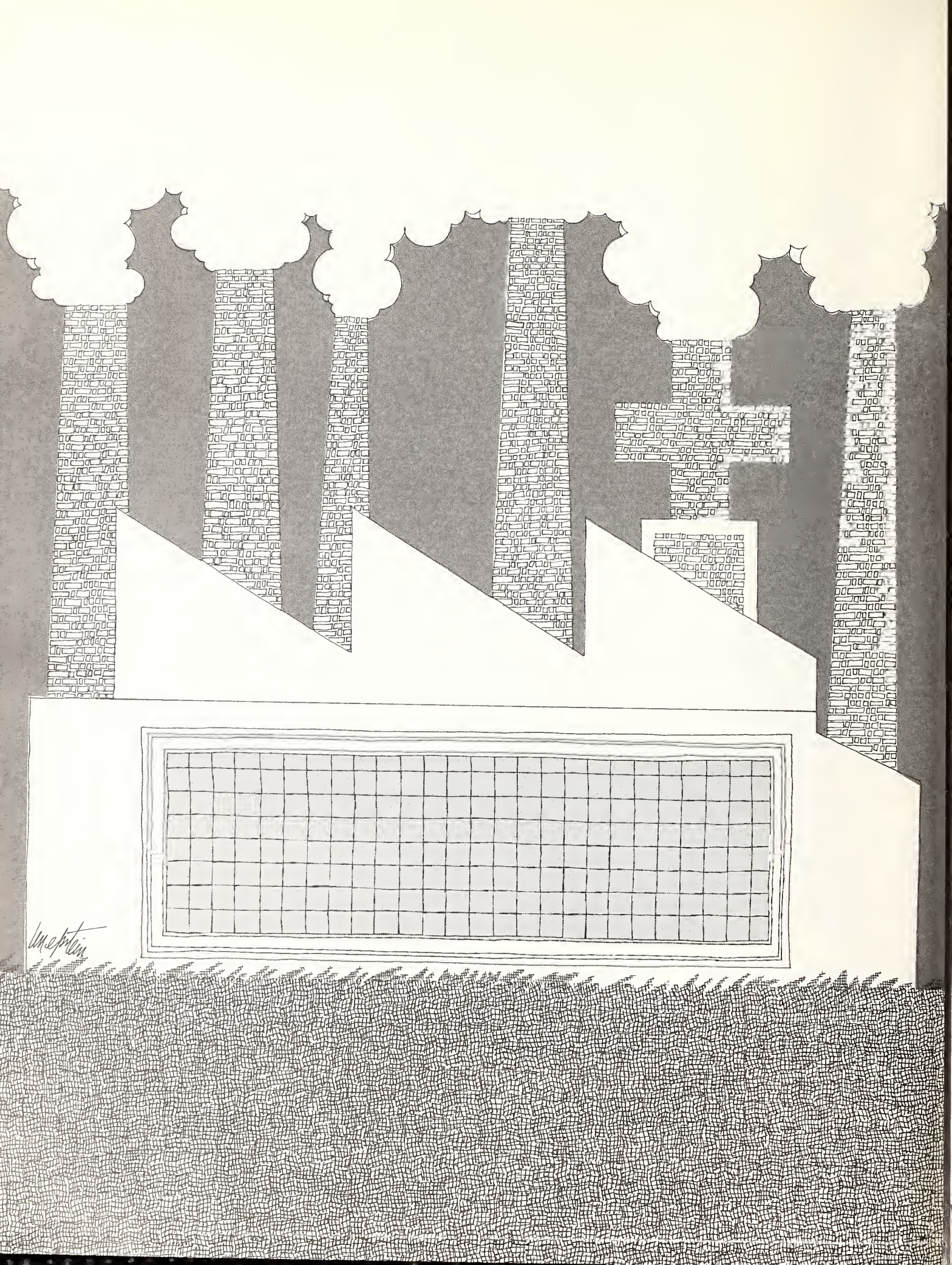
Pediatrics

The physician assistant shall be able to record the history of and perform the physical examination on pediatric patients as directed by the responsible physician, institute medical treatment for pediatric patients following presentation to the responsible physician, and perform procedures necessary to sustain life in any pediatric patient who is threatened by a life endangering emergency until the arrival of the responsible physician. ■

Seeing is believing.

He will never find the answer if he can't see the problem. If your child needs glasses, the Medicaid Program can provide them. Just as we provide immunizations against polio, whooping cough, and measles . . . treat anemia, TB, and sickle cell disease. To find out if your family is elegible, contact your local Social Service or Welfare Office today. Medicaid. Worth looking into.

For a free supply of these posters, write: Editor, the *Forum*.



Trends in Employer Health Insurance May Stem Rising Costs.

by Willis B. Goldbeck

From 1974 to 1978, health insurance premiums for families rose 103.1 percent for employees at Exxon's New York headquarters. Less than 15 percent of this increase was attributable to improvements in the benefit package.

Such cost increases have awakened industrial leaders to a new appreciation for the degree to which their employee benefit plans influence the behavior of both patient and provider and the awesome influence industry's collective purchasing power could have upon future health policy.

Every American is affected by employee benefit plans because employers must pass along the cost increases through price increases for products, restraints on wages and/or other compensation, as well as diminished stock dividends.

The major expansion of employee health benefits occurred during the World War II wage freeze, and since 1950 growth in insurance coverage has been dramatic, followed by growth in benefits. In 1950 commercial carriers and the Blue Cross and Blue Shield Associations paid a total of $962 million* in medical claims, compared with $16 billion in 1971 and $32 billion in 1975. Dental claims were also on the rise, with $286 million paid in 1971, compared with $1.7 billion in 1976.

Two primary forces guide the future of employee health benefits—and they are in serious conflict. Those forces are: cost containment, which is of equal importance to labor and management, and employee demands for increased insurance coverage, whether through a union or not.

Ironically, the reasons for both are the same: fear of the ever-increasing cost of medical care and the perception that much of the money is wasted if measured by results.

Trends in corporate health care that can be predicted with reasonable certainty are:

- More companies becoming self-insured, or more properly, self-funded, in order to reduce costs without reducing benefits. Deere and Company, which has 50,000 employees, began self-funding about 7 years ago. Company spokesman Kevin Stokeld said this about the experience: "We are administering our own plan at a rate appreciably less than the best rate we could obtain from an insurance company, and that does not take into account the interest on reserved credit and state premium taxes. There are other advantages that we think we obtain as well—a more coordinated approach and better employee understanding. The union likes the plan."
- Expanded corporate clinics and other forms of direct provision of care rather than provision of insurance.
- Increased employee enrollment in and corporate sponsorship of health maintenance organizations. Bynum E. Tudor of R. J. Reynolds, Inc. puts the case for health maintenance organizations this way: "When you have your own HMO, you have your own utilization review, quality control, data system, and a communication vehicle with the beneficiaries built in."
- Expanded use of coinsurance and deductibles, to which many employees do not object, if they are given options on the total cost.
- Continued increase in the upper limits of catastrophic coverage. Many policies have unlimited coverage, although few claims ever exceed $50,000.
- Growth of dental and vision care as the two most popular new benefits to be covered.
- More tightly designed yet expanded mental health benefits, especially as the evidence mounts that good programs can reduce hospital, surgical, and medical use.
- Increased use of financial incentives to guide employee benefit use. These range from providing greater coverage for lower cost care settings to direct cash bonus experiments.
- Reimbursement designed to provide the financial incentives necessary to alter provider behavior, such as paying for allied health professionals.
- Reimbursement designed to encourage more attention to preventive care procedures, such as immunizations and well-baby care.
- Greatly increased attention to employee life styles through health education and such specialized programs as: physical fitness, smoking cessation, stress management, marital and sexual counseling, obesity con-

*Includes dental costs

Willis B. Goldbeck is executive director of the Washington Business Group on Health.

trol, drug and alcohol abuse clinics, nutrition information, and off-job safety programs.

- Increased requirements placed on benefits such as pre-admission testing, second surgical opinions for elective surgery, concurrent utilization review, disability review, and reimbursement only to those institutions approved by the local health systems agency.

Corporate medical programs

Between 1974 and 1975, a survey of 49 companies reported that their employees were given 7,206,281 treatments in company facilities. There is insufficient data to accurately project the volume of treatment performed in all corporate settings, but it is easy to see that if these treatment centers were closed, it would have a major impact on the normal delivery system.

The size, breadth and professionalism of corporate medical departments are growing, as companies find that the more they can do for themselves the more cost containment they can build into program management. They find, too, that financial savings result in eliminating travel time to outside medical facilities, quite apart from the savings of internal treatment and the prevention factor.

Discussions of employee benefit programs often fail to note the important role played by the company medical department. A survey by the Washington Business Group on Health in late 1976 and subsequent investigation indicate that the following is a good profile of company benefits:

- Among the major employers, nearly 90 percent have corporate medical facilities.
- The most common services are pre-employment exams (93 percent) and other physical exams and emergency care (94 percent). However, there is a definite trend toward more full-service clinics.
- Most companies (87 percent) offer their facilities equally to all levels of employees, with the occasional exception of extra facilities or services for some executives. Only a few companies open their facilities to dependents or share facilities with other employers or with the community. There is some evidence of expanding the use of these facilities but not enough to report a real trend.
- More than 80 percent of the companies paid the complete cost of medical department services.

Industry's changing attitudes toward health care were expressed recently by Dr. Gilbert H. Collings of New York Telephone: "With almost religious fervor, occupational medicine has tried to stay out of all areas that were not related to jobs. Distinctions between occupational and non-occupational were actually the daily drift of occupational medicine, often winding up in litigation to determine whether a condition was or was not caused by the job. Before treatment could begin, the occupational physician had to determine whether the patient was in his legitimate province or that of those guys out there in the community.

"Also, the medical profession has generally regarded occupational medicine as some kind of bastard stepchild out there in never-never land. It's going to take us a long time to get over that attitude, because it is deeply ingrained. It is perfectly obvious, if you look at it from a logical standpoint, that the definitional boundaries between occupational and non-occupational are not only disappearing but were probably not there in the first place, because there is not very much you can point out to me that is solely occupational or non-occupational."

Mental health benefits

One factor of employee benefits which has received increased attention is mental health. Preliminary returns from a survey on corporate mental health programs by the Washington Business Group on Health produced a profile of benefits. The profile is based on returns from 79 companies, all of which had some

Spiraling Benefit Costs.

Benefit cost increases in recent years have been staggering. The extent of these increases can be seen in the following examples:

- From 1972 to 1977 the cost of the IBM comprehensive medical benefit plan per employee increased by more than 70 percent with no major change in benefits.
- The monthly premium of each active TRW employee in the Cleveland area rose to $105.60 this year, reflecting a 15 percent per year increase compounded for 3 years in a row.
- In 1977 Stauffer Chemical's health benefit costs jumped 14 percent to $830 per family per year, equalling 3.8 percent of the company's payroll.
- Despite no change in its benefit package and no appreciable increase in the number of persons covered since 1973, costs per employee for this primarily rural group at St. Regis Paper rose from $433 in 1973 to $684 in 1977. More than 25 percent of this increase came between 1974 and 1975.
- In 1977 Ford Motor Company's premium increase, with no benefit improvements, was $100,000,000.
- Cost per active employee with no major change in benefits for Sherwin-Williams more than doubled from 1974 to 1978. The increase: $370 in 1974; $555 in 1976; and $894 in 1978.
- The cost of the total benefit package at Standard Oil of Indiana nearly tripled between 1972 and 1978, with the contribution made by the company rising from 66 percent to 89 percent.

type of program. Alcoholism and stress management are included within the mental health category.

Of the companies surveyed 96 percent have equal mental health benefits for all employees, with the most common coverage being for schizophrenia, depressive disorders, and alcohol and drug disorders (71 to 90 percent). The benefits are extended to dependents (between 61 and 90 percent, depending upon the benefit) and to retirees (between 37 and 67 percent). Consultations for family, marital and sexual problems are just beginning to be included as benefits with less than 25 percent of the companies offering them.

There is an almost even split between those companies which pay the entire premium for mental health benefits (52 percent) and those which share the cost with the employees (48 percent). For those sharing the cost, the employee's portion is usually limited to 20 percent.

Only one of the 79 companies uses a prepaid program. The rest use Blue Cross/Blue Shield (33 percent) and commercial carriers (72 percent), with some having coverage divided among more than one class of carrier.

Each company was asked to list the areas in which it felt mental health benefits helped the company. Their responses:

- Improved employee morale, 52 percent
- Lowered employee absenteeism, 53 percent
- Fewer instances of mental illness, 51 percent
- Improved employee productivity, 53 percent
- Reduced hospital use, 46 percent
- Lower total insurance premiums, 16 percent

It is common knowledge that the incentives provided by the traditional reimbursement system, combined with benefit designs, have encouraged the use of the most expensive facilities and treatments. The companies were asked a series of questions to see if the same problems were being built into the mental health benefits.

Their responses to this survey were mixed. Forty-nine percent allow charges for treatment in an inpatient facility other than a hospital. All except one of the companies cover charges of a physician for psychiatric treatment in outpatient settings. However, these benefits typically carry a 20 to 50 percent copayment, and some also involve a small deductible.

Nearly 65 percent allow charges by a physician or hospital for psychiatric treatment under "in-residence" programs where the patient may be allowed to go home at night or to work during the day, in order to prevent complete severance from a natural environment. And some 80 percent provide reimbursement for mental health practitioners other than physicians. Specifically mentioned were psychologists, who generally were covered to the same extent as psychiatrists; social workers, covered less frequently, and often limited to team work in a "recognized" facility; and psychiatric nurses, rarely covered.

The increasingly modern attitude toward employee mental health can be seen by the statement of General Foods Chairman James L. Ferguson: "It is estimated that as many as 15 million working Americans may be troubled by alcoholism, drug abuse, mental illness, or emotional problems caused by family or financial problems. These illnesses strike at all organizational levels in industry. No one is really immune. Fortunately, if illnesses of this kind are detected and treated at an early stage, they can usually be overcome. General Foods, where you spend almost a third of your life, is concerned about these illnesses and wants to help its troubled employees. Help will be given professionally, confidentially, and with full respect for the dignity of the individual."

Management and labor

Health care cost escalation has had the positive result of forging closer ties between management and labor on many health issues. This is not to suggest that the two sides do not differ on such broad policy topics as national health insurance and the traditional pressure from labor to expand benefits, while management tries to limit that expansion.

Not only will these differences continue, they are an appropriate expression of very legitimate perspectives with different incentives and constituencies. However, the past year has seen a growing realization that everyone is hurt by cost escalation and that only through large doses of cooperation can a cure be effected.

There have been many signs of labor-management cooperation this year which will have a significant impact on the design and use of future benefit plans. For example, in March George Meany of the AFL-CIO joined Charles Pilliod of Goodyear in addressing HEW Secretary Califano's National HMO Conference. One result of that conference was the establishment of a private sector HMO Council composed primarily of labor and management leaders.

In June, the ad-hoc labor-management group, coordinated by Former Secretary of Labor John T. Dunlop, and representing leading industrialists and union presidents, issued a set of position papers on health care issues. The group recommended support of:

- Prospective reimbursement
- Development of HMOs
- Health planning, as established by P.L. 93-641
- Hospital pre-admission testing
- Prospective surgical review (second opinion program)
- Concurrent utilization review
- Alternatives to inpatient treatment
- Use of nurse practitioners
- Cost effective assessment and management of new medical technology
- Arbitration to resolve malpractice claims
- Health education for the public, for providers, and as an integral element of all employee benefit plans

Separately, each of these items is of rather minor significance. Collectively, they signal a new awareness of the necessity for management and labor to work more cooperatively to achieve employee health benefit plans that emphasize health and cost effectiveness and are employee oriented rather than provider oriented. ■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Supermarket of Services Allows Dependent Adults To Avoid Institutions.

It is generally acknowledged that most elderly persons would rather live in their communities than in nursing homes. But the nagging questions have always been: can they adequately care for themselves in that environment; is their quality of life really improved; and does such an arrangement cost more or less than nursing home care.

In an attempt to definitively answer these questions, HFCA, 2½ years ago, funded* the longest pilot project of its type. Now, at the halfway point of the project, the data indicate that the quality of life of elderly, blind, and disabled adults can be improved, and the cost for many is not as expensive as living in an institution.

The objective of the project, which operates in three Wisconsin counties, is to assess the needs of participants, supply them with a virtual supermarket of services to fill those needs, and continually monitor their progress, changing the mix of services to correspond with changes in their needs.

Services of the project range from comprehensive health care to such mundane but necessary chores as snow shoveling and meal preparation. Included are skilled health services, medical equipment and supplies, medical therapy and medically-oriented day care, home care and homemaking services, chore services, home repair and reconditioning services, meal services, transportation, counseling, protective services, legal and financial representation, social therapeutic services and adult day care, visiting, companionship, social and recreational services, reassurance services, and housing. (See accompanying box.)

This pilot project, known as the Wisconsin Community Care Organization Project, operates one center in an urban county, one in a rural county, and a third in a county with an urban-rural mix. Each center is responsible for finding persons who appear to need its assistance—that is, those who may be about to enter institutions prematurely.

Those eligible to participate in the project are generally eligible for Medicaid benefits and meet the project's criteria for imminent transfer to an institution. The project has received waivers which allow centers to purchase services not customarily covered by Medicaid and other federal programs.

Each center determines the package of services needed by its participants. If a new participant in the project needs a service which is not offered, a center would facilitate its establishment, even providing funding for it if it were not otherwise available.

Since the centers began opening in staggered fashion in April 1976, more than 2,200 persons have been referred to them for assistance and over half have been helped to continue living in their communities. Sixty-eight percent are elderly, 31 percent are disabled, and 1 percent are blind.

Analysis of the first collection of data (interviews with participants) shows that the quality of life of those participating in the project is significantly better than before. The average project participant reported that he perceived improvement in the quality of his life in all 11 categories measured, while the average member of the control group perceived improvement in only 5 categories. (See accompanying table.)

"The interview was designed to measure perceptions of the quality of life in key areas that we know are important to the elderly," says Dr. Fred Seidl, associate director of the University of Wisconsin's School of Social Work and the coordinator of the university program under contract with the state to evaluate the project.

Cost Savings

Early data analyzed by project officials indicate that the average cost of the specially tailored packages of services is about the same as the cost of nursing home care, provided the cost of developing the centers is not considered. However,according to project officials the cost of caring for persons with chronic mental disabilities is much greater in mental institutions than in nursing homes—up to $200 a day vs. about $20 a day for nursing homes. Therefore, when the cost of caring for such patients in the community is broken out, the project's average patient cost is expected to be below that of institutional care.

A center contracts for services rather than provides them. Contracts are written for services on an "as needed" basis, rather than for a guaranteed dollar volume and are awarded only after it is determined that the cost of the services would be no greater than prevailing rates. This policy has been followed because the volume of services needed could not be accurately projected. Project officials believe that this method of payment also will prove to be more cost effective in the long run rather than purchasing a guaranteed volume.

Another cost saving measure is encouraging families and volunteers to help provide care. In addition, the high cost of professional staffing is held down by using paraprofessionals whenever possible. After two years of operation, the project reveals that most assistance essential to community living can be provided by paraprofessionals. A study of services at the La Crosse center shows that only 2 percent of the project's funds are spent on high-cost professional services, while the two largest cost items are relatively low-cost services: security, 55 percent of the budget; and home maintenance, 33 percent of the budget.

Determining eligibility

Two of the three centers admit

*The Kellogg Foundation provided the state's share of $343,000 in matching funds for start-up costs. An estimated $7.5 million in federal and state funds is expected to be spent for services during the 5-year project.

only those persons who are covered by Medicaid. The La Crosse County center admits all persons who meet the criteria of being on the brink of institutionalization due to age, disability, or blindness and receives payment according to their ability to pay. Admission standards for La Crosse were lowered in order to assure a sufficient number of participants for statistical comparisons.

The probability of a person's entering a nursing home or other institution is measured by the Geriatric Functional Rating Scale. A score of *20* or below indicates a very high likelihood that a person will enter a nursing home within 18 months.

To test the success of the project with persons of different disability levels, as each center opened the requirements for acceptance became stiffer and a lower score on the GFRS was required. The La Crosse center, which opened in April 1976, permits a rating of up to 50; the Barron County center, which opened in July 1977, requires a rating of 40 or less; and the Milwaukee center, which opened in December 1977, draws the line at 20.

Assessment of need

When a person is found eligible for the project his needs are assessed by a team composed of a social worker, a nurse, an interviewer, and the center's case coordinator. The case coordinator identifies sources of services and determines which agencies can provide them most suitably.

Case management

The end product of the assessment is the formulation of a Case Plan and Order for Services form. This form incorporates the areas of care in which the participant needs assistance, the services to be received, and the agencies that will provide them. Because a participant's condition can change, at the time of assessment a date is set to review the case plan based on the participant's response to services. A prime directive of the project is that the case plan must be considered a flexible document, subject to change whenever warranted by a change in the circumstances of the participant.

Although each center differs in how it organizes primary responsibility for case management, in general, work on bringing services to a participant begins within two days after the case plan is drawn up. The plan is set in motion when the center's case coordinator contacts the lead agency—that agency which will play the most active role in the case. The lead agency assigns a manager for the case who will be responsible for assuring that the participant receives all services promptly. Duties of the case manager include:

- Explaining the case plan to the participant and relatives or other responsible persons
- Evaluating the adequacy of services ordered
- Monitoring services and maintaining liaison with all agencies involved
- Serving as the day-to-day link between the participant and the center
- Reporting to the center any problems in the delivery of services and changes in the participant's situation requiring changes in the case plan

Early problems

Predictably, problems arose in overall case management when the centers were established. Some members of community agencies saw the centers as a threat; others viewed them as a mixed blessing. There was a degree of resentment and some professional exception to a new organization coordinating services of agencies that had served their communities for many years.

For example, when the case coordinator of one center sent out a short questionnaire to agencies providing services to its participants, one questionnaire came back with the notation: "Not only does the patient not need the service in question, but it would be to her best interest not to receive it." Representatives of other agencies reported that staff members felt it was inappropriate for an outside organization to dictate in "areas of professional discretion."

A month after community agencies assumed the duty of case management, a meeting was held to discuss the project. During the meeting representatives of two agencies were asked how many case managers they had. Neither gave a prompt response and one said that "our nurses are still doing what the have always done in terms of case management; they never knew they were supposed to check up on what other agencies were doing for the patient or that they were supposed to contact the center." Most agencies were also lax in reporting their work on cases to the lead agency's case managers.

The problem of control by the centers stemmed from the lack of incentives and sanctions vested in them. All the community agencies already had some form of funding that was independent of contracts with the centers —Medicaid, Medicare, Older Americans Act, Comprehensive Employment Training Act, or county funds. The centers can supplement those funds after they have been exhausted, but the supplemental funds are of varying importance to each agency.

As the project progressed, there was a growing awareness that many added services could flow into the community only through center funds. The key mechanisms that ultimately fostered close cooperation between the agencies and the center, and

Percent of Dollars Spent on Services at La Crosse Center

Type of Service	Percent of Total Dollars
Health	.2*
Personal Care	3.4
Home Maintenance	32.9
Nutrition	.1
Transportation	4.7
Security	55.2
Support	1.1
Day Care	2.4
Housing	0

Quality of Life Ratings by Project Participants and Control Group

La Crosse

To test the change in the quality of life of project participants, each was asked a series of questions about his life when he enrolled in the project and again six months later, The same procedure was followed with a control group. The average change in quality, listed below, shows life for the La Crosse participants improved 2½ times more than that of the control group. The La Crosse group showed improvement in all categories, while the control group improved in only five. In tabulating scores, participants were divided into four categories according to their scores on the Geriatric Functional Rating Scale: −200 to 19.9; 20 to 39.9; 40 to 100. and 40 to 100.

Life Quality Categories	−200 to 19.9	20 to 39.9	40 to 100	Total
La Crosse				
Close person	+40	−11	+11	+13
Life as a Whole	+49	+31	+41	+41
Accomplishment	+81	+80	+63	+71
Leisure	+56	+55	+98	+79
Respect	+19	−02	+18	+14
Friends	+44	−15	+13	+15
Money	+51	+55	+31	+41
Community	+23	−12	+10	+09
Government	+39	+70	+16	+32
Central Values	+18	+09	+15	+14
Services	+19	+15	+09	+13
Total	+30	+31	+24	+27
Control Group				
Close person	*	−14	+04	−05
Life as a Whole	*	−15	−17	−14
Accomplishment	*	+53	−15	+17
Leisure	*	+31	+06	+16
Respect	*	−05	+21	+07
Friends	*	−18	+18	−01
Money	*	+51	+44	+47
Community	*	+05	−13	−03
Government	*	+1.49	+96	+1.22
Central Values	*	+04	+21	+12
Services	*	−04	+25	+10
Total		+19	+04	+11

Classification of Participants	Number	Percent
Adults Over 65	218	68
Blind	3	1
Disabled Under 65	100	31
Total	321	100

Type of Service Provided During 22-Month Period at La Crosse

Services	Number	Percent
Housekeeping	32	18
Housekeeping/Meal Provision	25	15
Housekeeping/Companionship	14	8
Housekeeping/Errands-shopping	4	2
Housekeeping/Transportation	12	7
Personal Care	9	5
Personal Care/Meal Provision	10	6
Personal Care/Housekeeping	32	18
Day Care/Transportation	4	2
Companionship	6	3
Companionship/Meal Provision	7	4
Companionship/Personal Care	6	3
Transportation	7	4
Miscellaneous-combination	102	57
Miscellaneous-non-combination	54	20
No services/missing	30	17
Total	356	100.1

*Dental and pharmaceutical expenses are not included.

among the agencies themselves were:

- Interlocking boards. In fact, one county created a new committee called the Community Care Organization Project Committee, composed of members from county committees on social services, health, aging, and mental health
- A joint planning process, with a task force composed of agency directors and supervisors handling managerial tasks
- Formal contracts for services initiated between the centers and the agencies providing services
- A joint assessment of each participant in the project and a formal case plan
- A case management system, which placed management responsibility within the lead agency

Nursing home discharges

In addition to preventing inappropriate institutionalization, the centers also work to have patients discharged from institutions. In its first 1½ years of operation, the La Crosse center, for example, assisted in having 45 nursing-home patients discharged and resettled in the community. This was accomplished in part through better working relations between the center and the nursing homes, and by better case follow-up.

Twenty-five of the patients discharged were identified as having that potential by nursing home case managers. Ultimately, 20 of the 25 were discharged.

A second group of patients was identified as having potential for discharge by nursing homes' staffs and all were discharged. Only 3 of the 11 returned to the nursing homes, 2 within 6 months and 1 within 12 months.

A third group of 10 patients contacted the center and said they felt they could live in their communities with assistance. All were discharged and, although each had an extremely strong desire to remain in his community, 6 were readmitted to nursing homes—one within 6 months of discharge, 2 within 12 months, and 3 after 12 months.

A fourth group of patients was

recognized as having discharge potential when they entered the nursing homes. Four were discharged, 1 was not, and 1 was awaiting discharge.

In the four groups, nearly all of those discharged were patients for less than a year: 19 for less than 3 months, 14 for between 3 and 6 months, and 10 for between 6 and 12 months.

During the next 12 months, project managers and the evaluating agency will be formulating conclusions about the effectiveness of the project, from both the viewpoint of costs and quality of life. Since this is the longest HCFA-funded project of this type to date, it is expected to yield extremely valuable data. Says Project Director Don Wilson: "I believe the data we are now formulating from these three centers will be very useful to policy makers, consumer groups, and others responsible for designing effective delivery systems for dependent adults." ■

Major Services of the Project.

The Wisconsin Community Care Project offers more than 20 services to persons participating in the project. In some cases, similar components are included under two or more services. In other cases, the components of services are the same, but differ in levels of intensity. Major services include:

- *Skilled health care services* are designed to prevent and relieve problems caused by physical and mental disabilities. Services include medical, surgical, and skilled nursing home care; immunization; prescribing and administering of medications; and health care instruction. Care is provided by appropriate professionals.
- *Home health services* include assistance with personal care, hygiene, prescribed exercises, medication, and incidental household services, such as meal preparation, shopping, and light housekeeping. Services are performed by home health aides, homemakers, and other qualified persons according to an established plan of care.
- *Medical equipment and supplies* are furnished to: (a) compensate for physical disabilities that interfere with a participant's independent functioning; (b) cosmetically correct a physical deformity; and (c) assist the nurse or her aide in providing necessary services. Care may be provided by an orthopedist, prosthetist, brace fitter, corsetierre or other qualified personnel.
- *Therapeutic medical services* are provided in a rehabilitation center, or a hospital outpatient department. Physical services are usually performed by certified physical, speech and occupational therapists, audiologists and their trained aides.
- *Home care/homemaking services* assist the participant with day-to-day tasks in the home. Services may include any combination of laundry, shopping, transportation, housekeeping, personal care, meal preparation, financial management, errands, and companionship. The care may be provided by a member of the participant's family, a private home care provider, a homemaker aide, a homemaker or other supervised paraprofessionals.
- *Chore services* consist of performing household tasks such as shopping, lawn mowing, snow shoveling, and minor painting.
- *Home repair and reconditioning services* cover such tasks as roofing, electrical and plumbing repair, and installation of wheelchair ramps, stairways, handrails, and grab bars. These services are performed by a handyman or a skilled craftsman.
- *Meal services* consist of the regular delivery of meals to the participant.
- *Transportation services* enable participants to travel to and from other services, and bring materials to them.
- *Counseling services* are designed to promote a sense of well being within the participant by improving his ability to cope with stress. This includes treatment for mental, emotional, and social problems.
- *Protective services* are intended to protect participants who are vulnerable to abuse or exploitation.
- *Legal and financial services* cover such matters as taxes, contract disputes, medical assistance eligibility, court appearances, and resolution of complaints.
- *Social therapeutic services* and adult day care services offer supervised, planned programs which may include opportunities for companionship and self-education. These services are provided outside the participant's home by a social worker, or a qualified professional, or trained aides.
- *Visiting services* consist of regular visits to the participant's home for social contact, and are generally performed by a volunteer.
- *Companion services* provide care and protection for the participant within his home on a day, night, or live-in basis.
- *Housing services* are provided for the participant on a short-term, long-term, or emergency basis. This includes finding new housing and renovating existing housing. ■

Leonard Schaeffer named HCFA Administrator.

Leonard D. Schaeffer, 33, former HEW Assistant Secretary for Management and Budget, has been appointed Administrator of the Health Care Financing Administration. He replaces Robert A. Derzon who became Administrator shortly after HCFA was established.

Before joining HEW, Schaeffer served as a vice president for financial and business planning at Citibank in New York. Prior to that he served in top executive positions in Illinois from 1973 to 1977, first as deputy director for management of the Department of Mental Health and Developmental Disabilities and later as director of the Bureau of the Budget for the state.

Schaeffer earned a bachelor's degree at Princeton University in 1969, joined Arthur Andersen & Co. as a management consultant, and served as vice president of Charles H. Eldredge & Co., an investment firm, from 1971 to 1973.

Legislation gives NY State control of hospital rates.

New York State has established direct control of hospital rates, under a bill recently signed into law by Governor Hugh Carey and all rates are to be frozen at their May 1 level for the remainder of 1978.

A panel of four experts in health economics will assist the state's Commissioner of Health in determining future rate increases. The legislation followed a New York State Court of Appeals decision that hospitals could avoid the state's previous indirect control of hospital charges by withdrawing from Blue Cross.

Modifications proposed in Medicaid residence rules.

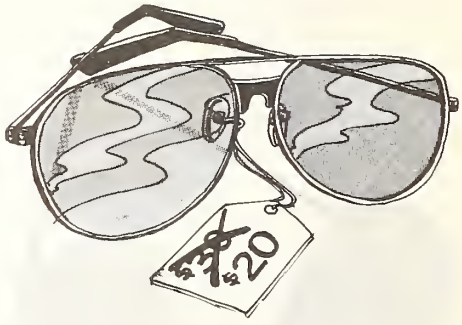
Persons denied Medicaid coverage because states cannot agree on their legal residence will be protected from loss of benefits under new regulations proposed by HEW's Health Care Financing Administration.

When a person leaves one state and applies for Medicaid coverage in another, sometimes neither state will consider him a resident and both deny Medicaid benefits.

New regulations would provide a workable method of resolving residence disputes. For instance, a state would not be allowed to deny Medicaid enrollment because the person had not established residence in the state before entering an institution. Problems occur most often when Medicaid beneficiaries enter long-term-care facilities. Another frequent problem is when highly mobile workers, such as migrant farm laborers who follow the harvest from state to state, are denied Medicaid benefits because they are only temporary residents.

To resolve this, the proposed regulations would change the definition of a resident to "one who is living in the state with the intention to remain there permanently or for an indefinite period, or is living in the state for purposes of employment." Current regulations say a resident is "one who is living in the state voluntarily with the intention of making his home there and not for a temporary purpose."

Other proposed changes relate to determining a child's residence for purposes of Medicaid eligibility, eligibility of a person placed in an out-of-state facility because the first state lacks appropriate facilities, and interstate agreements on Medicaid eligibility.



Medicaid proposes savings on glasses, hearing aids.

Prices paid for eyeglasses and hearing aids by the Medicaid program could drop as much as 50 percent under a new method of reimbursement recently proposed by HEW Secretary Joseph A. Califano, Jr.

Currently, federal regulations provide reimbursement to states at the going rate for eyeglasses and hearing aids sold in a given area. Secretary Califano pointed out that many times these rates are unreasonably high. He said the Medicaid bill for glasses and hearing aids last fiscal year was about $100 million, of which the federal share was 55 percent.

The proposed regulations, published in the *Federal Register*, pointed out how volume purchasing of the devices cuts costs sharply. A 45-day period is allowed for the public to comment and suggest changes.

Eyeglasses for adults are paid for by 33 state Medicaid programs, and hearing aids are paid for by 27 States. All states must provide the devices to children who are eligible and need them.

Value of CT scanners supported by study.

Two conflicting reports have been issued on the computerized tomography (CT) scanner, the new diagnostic tool for locating tumors in the adrenal gland that cause high blood pressure.

In August Congress' Office of Technology Assessment released a study claiming that the CT scanners have gone into widespread use in hospitals without good medical evidence that they are a real improvement over current diagnostic methods. Their benefits, said the report, do not justify the $400,000 cost per machine.

A rebuttal has now been introduced by five doctors at the Cleveland Clinic Foundation writing in the August 31 issue of the *New England Journal of Medicine*. They say that not only can the CT scanner locate the tumors just as accurately as arteriography, but that the potential complications of this standard method are totally eliminated.

The CT scanner takes x-rays of cross sections of the body which are reconstructed by computer into three dimensional images displayed on a television screen.

Infant mortality rates drop in U.S.

Infant mortality rates for the United States continue to drop, according to the National Center for Health Statistics. For the 12-month period ending April 1978, the center reported a rate of 13.8 deaths per 1,000 live births, down 6.8 percent from the previous year. For infants under 28 days, the death rate dropped 8.6 percent over the same period to 9.6 deaths per 1,000 live births.

Regulations to disclose owners of health services.

To detect and prevent potential fraud and abuse in its health care disbursement programs, HEW has proposed new regulations requiring private institutions, organizations, and agencies to disclose their ownership and other business arrangements.

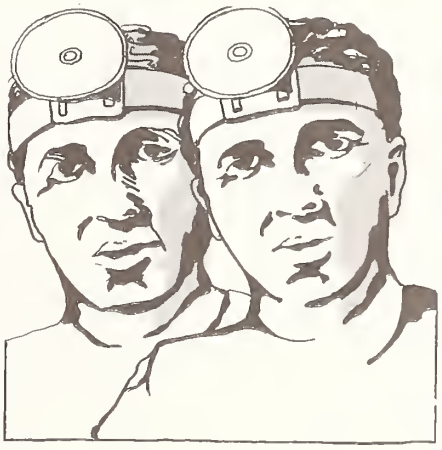
"These rules . . . will help us identify situations in which self-dealing, interlocking directorates, and other arrangements allow providers to make excessive profits," said HEW Secretary Joseph A. Califano Jr.

The proposed regulation sets three requirements for groups providing care to beneficiaries of the Medicare, Medicaid, Maternal and Child Health, and Title XX Social Services Programs.

First, any organization providing health-related services under the programs must disclose to HEW the identity of persons with certain ownership or interests in the organization or any of its subcontractors.

Second, providers under the Medicare, Medicaid, and Title XX Social Services Programs must disclose the names of owners or managers who have been convicted of criminal offenses involving any of the programs. If providers fail to disclose this information at the time it agrees with HEW to deliver health care services, HEW may terminate the agreement.

Third, all Medicaid records must be, as Medicare records already are, accessible to HEW.



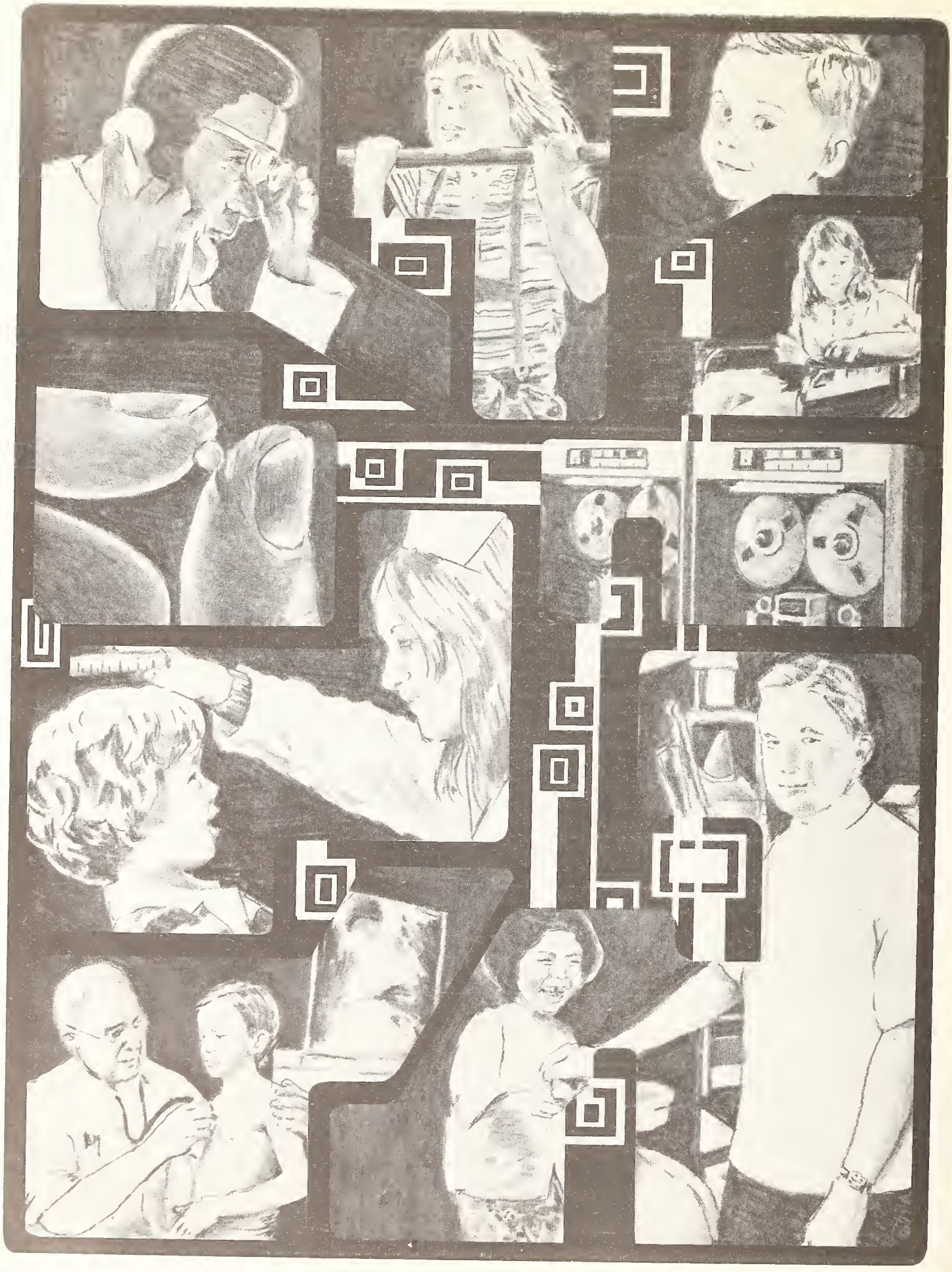
Physicians volunteer to give second opinions.

The Medical Association of Alabama is asking all physicians in the state to provide second opinions when requested in cases of elective surgery involving Medicare patients.

A list of physicians willing to provide second opinions is being compiled by Alabama Medical Review, Inc., the state's peer review organization and a referral center with a toll-free telephone number will be set up. A registered nurse will screen calls and refer callers on the basis of the specialty required and the location of the patient.

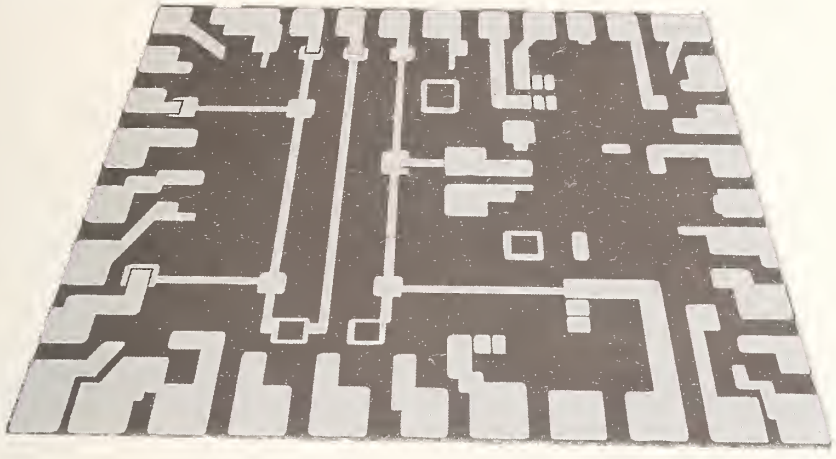
In Maine recently, the Cumberland County Medical Society set up a second opinion program. All 83 of the society's surgeons have agreed to offer free second opinions to patients for whom surgery is recommended.

Continued on page 39



Less Paperwork and More Communication Aids South Carolina's EPSDT Program.

by John C. Miller



This is the fourth in a series of articles about successful techniques used by states in operating their Early and Periodic Screening, Diagnosis and Treatment Programs.

Back in the early 1970s an assessment of South Carolina's EPSDT program by the Federal Government showed that while the program was developing satisfactorily, a notable weakness was its lack of physicians and dentists to provide services to children.

But in the last few years, that weakness—not an uncommon one among state programs—has become a decided strength. The key to this turnaround is a much overworked and poorly handled concept: communication.

"The problem back in 1973 was that we were really not communicating our problems to the physicians and dentists nor were we asking them about their problems with the EPSDT program," recalls James Jollie, who became director of the state's EPSDT program that year and now serves as program administrator of the state's Bureau of Medical Assistance's Recipient Management Branch.

"For a long time we were not talking with each other—we were just casting aspersions," said Jollie. "Now, for the last 3 years we have had a dental committee composed of members of the South Carolina Dental Association; the Blue Cross and Blue Shield of South Carolina, that process our claims; and members of the Bureau of Medical Assistance. We hope to have a similar arrangement for physician care soon. Frankly, I can't see how any program can operate efficiently without professional input."

The effort to involve dentists and physicians in the program through better communication began in 1973 and reached a high plateau last January when the bureau held a workshop on billing for dentists. That giant step was the result of years of work with the South Carolina Dental Association. Communication began in earnest when the bureau formed its dental committee to help resolve problems that had plagued dentists since the program began. The problems: time-consuming, complicated paperwork and slow reimbursement for services.

To make paperwork easier and to reduce its volume, the bureau incorporated into its own billing form the standard examination form of the American Dental Association. This meant that dentists would not have to learn to fill out a new form, and it also eliminated the previous practice of filling out two forms, stapling them together and sending them to the fiscal agent for reimbursement. In addition, the identification of the patient was already imprinted on the form, eliminating another time-consuming task.

The workshop helped quell the fear of many dentists that a bureaucrat with no dental training would decide whether they were diagnosing and treating each case properly. They learned that while an administrator did review all claims, the review was only to assure that the claims conformed with the standards for treatment established by the bureau. The administrator made no decision on those submissions which did not conform but referred them to a staff consulting dentist for determination.

A second concern voiced at the workshop was the inflexibility of the rules governing treatment. For instance, a dentist would examine a child and find that a tooth had decay on two surfaces and should be filled. After duly reporting that and receiving approval for the treatment, the child would return, and the dentist would find decay on three surfaces of the tooth. Under the regulations, the dentist could repair only two sides and report that the third was in need of attention.

"The dentists told us that procedure was a very inefficient way for them to operate," said Jollie, "so we amended the process to reimburse them for repairing one more side than was first reported. We were willing to give a little in the interest of easing their problem, and they were willing

John C. Miller is a freelance writer specializing in the health care and social services fields.

SOUTH CAROLINA
DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR SERVICES
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

PART I - IDENTIFICATION

1 COUNTY	2 CHILD'S NAME (first - initial - last)	3 RECIPIENT NAME (PAYEE) (first - initial - last)	4 DATE

5 PERMANENT ADDRESS (Number, Street or Route, City, State & Zip Code)	6 PATIENT'S SIGNATURE	7 DATE

8 WAS CONDITION RELATED TO A. Patient's Employment ☐ YES ☐ NO B. An Auto Accident ☐ YES ☐ NO	9 SOCIAL SECURITY NUMBER	10 MEDICAL IDENTIFICATION NUMBER				
		COUNTY	CATEGORY	AWARD NUMBER	BIRTH DATE (Mo. Yr.)	SUFFIX

11 IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	12 DENTAL PLAN NAME	13 UNION LOCAL	14 GROUP NO.	15 NAME AND ADDRESS OF CARRIER

PART II - SCREENING

16 PLACE OF SERVICE _____ CLINIC

VENDOR NUMBER _____

MO. DA. YR.

CHECK APPROPRIATE BOX

1. ☐ HAS NO DEFECTS
2. ☐ HAS A DEFECT, NO DIAGNOSIS OR TREATMENT NECESSARY
3. ☐ HAS A DEFECT(S) REFERRAL NECESSARY

(1) DA	(2) PHY	(3) SC	(4) LP	(5) IMM	(6) PAR	(7)
☐	☐	☐	☐	☐	☐	☐

CHILD SHOULD BE REFERRED FOR DIAGNOSIS FOR THE FOLLOWING (No referral for known defects)

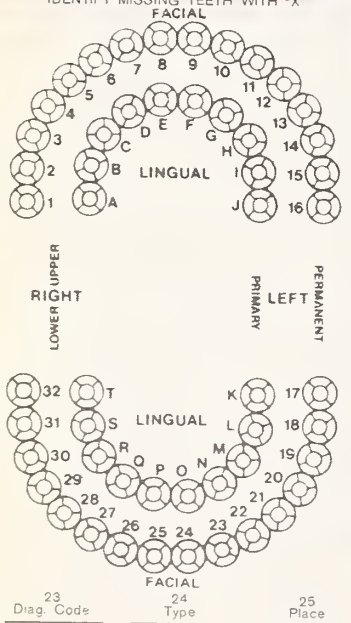
	PROBLEM CODE

SIGNATURE OF DSS COUNTY DIRECTOR	SIGNATURE OF SCREENER	TITLE OF SCREENER

PART III - DIAGNOSIS AND PLAN OF TREATMENT

MO. DA. YR.

IDENTIFY MISSING TEETH WITH "X"



EXAMINATION AND TREATMENT RECORD—LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.

17 TOOTH # OR LETTER	18 SURFACES	19 DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	20 DATE SERVICE PERFORMED MO. DAY YEAR	21 PROCEDURE NUMBER	22 FEE	USUAL AND CUSTOMARY / TABLE OF ALLOWANCE

23 Diag. Code	24 Type	25 Place

26 Providers Name, Address, Phone Number SSAN Employer ID Number

Provider's Signature

APPROXIMATE COST OF TREATMENT

27 Amt. Paid	
28 Bal. Due	
29 Max Allowable	
30 Deductible	
31 Carrier %	
32 Carrier Pays	

PART IV - A TREATMENT --- APPROVAL VALID CONCURRENT WITH ELIGIBILITY

☐ TREATMENT DISAPPROVED (REASON)

DATE

MO. DA. YR.

☐ TREATMENT APPROVED FOR USUAL, CUSTOMARY, & REASONABLE REIMBURSEMENT

SIGNATURE DSS M.A. DIVISION

PART IV - B - DATE TREATMENT COMPLETED

MO DA YR

Signature DSS County Director →

DSS FORM 1724 (REV. AUG. 76) EDITION OF AUGUST 1974 IS OBSOLETE

Vendor Copy

to help the program along.

"We found that by explaining a step-by-step chronology of the process and, probably more importantly, the rationale behind our regulations, they understood our problems and were, therefore, far more sympathetic. Of course, we knew that our amended regulations no longer posed unreasonable problems for dentists because the amendments had already received the concurrence of the dental association."

Faster reimbursement

To speed reimbursement for dental and medical services, the bureau developed a computer-based system which includes checks for errors and abuses by providers. The system works like this. After the dentist has examined the patient, he fills out a plan of treatment and submits it to the bureau for approval.

Once the plan has been approved by the state, a copy of it is returned to the dentist via the county office. At the same time a copy of the approved plan is also sent to the fiscal agent (Blue Cross and Blue Shield of South Carolina). At that time the fiscal agent codes the plan with the provider's number and enters it into a computer system. When the dentist's bill arrives at the fiscal agent, it is fed into the computer and matched line for line with the approved plan. If the bill includes a service that has not been provided or indicates a higher fee than was approved, the computer automatically rejects it. This eliminates the time-consuming step of having the fiscal agent manually compare the approved plan of treatment with the billing form.

In addition, the dentist does not have to wait for reimbursement until he completes all the approved services. He can bill after each visit by using a form preprinted with his name and address. This procedure has drawn acclaim from dentists and from the dental association.

"We now hope to elicit the same cooperation from the physicians in the state that we are receiving from the dentists," said Jollie. "Physicians' problems have been studied with the South Carolina Medical Association, and we will be sending out an explanation of our program to all physicians in the state. That mailing will contain a mail-back post card asking for their suggestions for improving the program.

"We realize that we may not be doing everything as effectively as possible, because fiscal constraints have greatly affected program expansion. By working with the physicians, we may be able to smooth out the wrinkles before they create problems. The next step in recruiting physicians will be to hold a workshop similar to the one staged for dentists last year.

"In anticipation of the enactment of the Child Health Assessment Program, and the increased volume of activity it will bring, we will begin certifying private physicians to examine children on July 1, 1979."

Monitoring the program

The computer is programmed to screen bills that are suspect for certain conditions, including duplicate billing. In addition, the bureau has two full-time employees who monitor the program. They randomly select files of children who have been examined and trace their paths through diagnosis, approval of treatment, treatment, and submission of bills. They also interview the patient or his parent to make certain that the services for which bills were submitted were performed.

When questionable billings are discovered, such as two claims for the same service, or a claim for more services than were approved, the monitoring team notifies the dentist or physician that it would like to review his records.

"Currently we have one team of two monitors, and we really need five teams to obtain the desired results. In spite of the lack of staff, however, this activity has proven very fruitful."

Motivating staff

Due to a moratorium on hiring throughout state government, the EPSDT program is operating with about 20 percent fewer staff members than it was 3 years ago. Nonetheless, the staff is still exceeding 30,000 examinations of an annual goal of 35,000. The reduction in staff has required the outreach effort to be virtually terminated in favor of case management. As it is, each case manager must handle about 600 children a year—roughly 20 percent more than in 1975.

But despite the extra load, treatment has been timely with the exception of a few isolated counties. The problem was eased somewhat when transportation contracts were signed and special authorization granted for neighbors to drive children to appointments.

"I think that morale has remained relatively high among our personnel despite the increased responsibility," Jollie observes, "because all the contributors to EPSDT understand the importance of this work. We explained at the beginning that it is our job to assist in medical referrals of poor children whose parents are unable to do it by themselves.

"During the initial orientation several years ago, some staff members sat with their mouths open in disbelief when we told them that children could develop irreversible mental and physical disabilities as a result of untreated disorders. We also stressed the positive results that could accrue if a problem is discovered early enough. I feel that the knowledge of the difference that they can make in children's lives sustains them in the face of short staff and day-to-day disappointments.

"We at the state office take the position that our staff is a service organization for the people on the line in the clinics. We tell them that their problems are ours, and its our job to help solve these problems." One method of doing this is through quarterly technical assistance sessions between the staff in each county and the visiting central staff. Another is a monthly newsletter which answers questions posed by the field staff, explains any changes in regulations or annual goals, and discusses progress to date toward annual goals.

Another key to maintaining morale is to set realistic goals. When a goal is not possible to meet, perhaps because of loss of a staff member or a reduction in provider capacity, the goal is adjusted to avoid an adverse psychological effect. In addition, care is taken to ensure that one goal is not

Update Report for August 1978 Anderson County (04)

Name	County	Cat	Case	Date of Birth	Sex/Race	Update Performed
Jim Simpson	04	3	01246	0467	L	New Case
David Taylor	04	3	16497	0467	L	Transfer Case From County 02
Beth Watson	04	3	18402	1069	K	Change of Birthdate from 01/15/75
Adrian Waters	04	3	20649	1271	K	Closed Case
Alex Poole	04	3	21411	0465	L	Removal
Theodore Smith	04	3	22705	0770	L	Addition
April Jones	04	3	23005	1163	K	Decline Screening

Summary

	New Cases	Transfers	Changes	Closures	Closures Plus Removals	New Cases Plus Additions	Decline Examination
Under 6	14	22	61	21	26	81	79
6 to 21	26	12	12	14	49	45	103
Total	40	34	73	35	75	126	182

Patient Status Report for Quarter 6/1/78—8/31/78 Anderson County (04)

Name	County	Cat	Case	Date of Birth	Sex Race	Examination	Referral	Diagnosis Date	Treatment Date	Payee Name
Jeffrey Adams	04	3	06341	1066	L	01/15/75	03	01/29/75	02/21/75	William Adams
Carol McKenzie	04	3	07911	1064	K	02/12/75	19	02/15/75	02/28/75	Susan McKenzie
John Farmer	04	3	09130	1065	K	03/10/75	03	03/15/75	03/26/75	Thom Farmer
Michael Baxter	04	3	10213	1268	K	01/15/75	15	01/19/75	02/25/75	Michael Baxter
Charles Galloway	04	3	13044	0470	K	02/11/75	02	02/21/75	03/16/75	Mike Galloway
William Bonds	04	3	17411	1065	L	01/26/75	12	02/06/75	02/19/75	Richard Bonds
Janet Pinner	04	3	22311	1057	L	01/15/75	32	01/19/75	02/09/75	Janet Pinner

met at the sacrifice of another. For instance, the staff will not examine more children than it can realistically guide through diagnosis and treatment.

Processing paperwork

The state office backs up the field staff with a simple, but effective computerized system for managing cases. Each week the 46 county offices where children are examined receive new cases and a status report on cases in progress (see accompanying table).

All the paperwork needed to process a case is prepared at the state office through a computer. The paperwork consists of a six-part form designed to minimize time spent by all persons involved in the process (see accompanying form).

When the caseworker receives the form, the child's identification is already imprinted on it. The person performing the examination need only check the appropriate boxes, note the date, place of service, vendor number and sign the form. After endorsement by the county director of the Department of Social Services, notification of the status of the case is sent to the bureau. If referral for diagnosis and treatment has been indicated, the form is sent with the child to the provider who will perform the diagnosis.

If the suggested treatment is on the state's approved list, the physician can treat the patient immediately. If not, the diagnosis and plan of treatment must be noted on the form and returned to the bureau for approval. All treatment involving dental work, vision and hearing must be approved before treatment, except in cases of emergency.

Upon approval of the treatment plan, the form is sent to the county office which makes an appointment for the child and delivers the form to the provider. When the treatment is performed, the provider sends a copy of the form to the state's fiscal agent for reimbursement. A copy of the approved plan of treatment has already been sent to the fiscal agent by the bureau, so the fiscal agent needs only to compare the two forms before making payment.

It is necessary to compare the forms because, in some instances, providers have added items for treatment after the form has been approved by the bureau. In the case of dental treatment, the child receiving treatment, or his parent, must sign the form indicating that the treatment listed has been completed.

"I think that the success of the EPSDT program in South Carolina shows what good communication can achieve," says Jollie, "particularly when you consider that our rate of examination and treatment has not fallen in the face of a diminishing staff.

"From the response of our own staff, the dentists and, thus far, the physicians, I can only conclude that people want to be involved in an important project—and there are few projects more important than the health of our children." ■

FREE!

For all state and local agencies and volunteer organizations. Eye-catching, full-color posters to publicize the Early and Periodic Screening, Diagnosis and Treatment Program.

Place it in churches, self-service laundries, welfare offices, unemployment offices, day care centers, store fronts, low-income housing developments, supermarkets, food stamp distribution centers and other places parents are likely to see them.

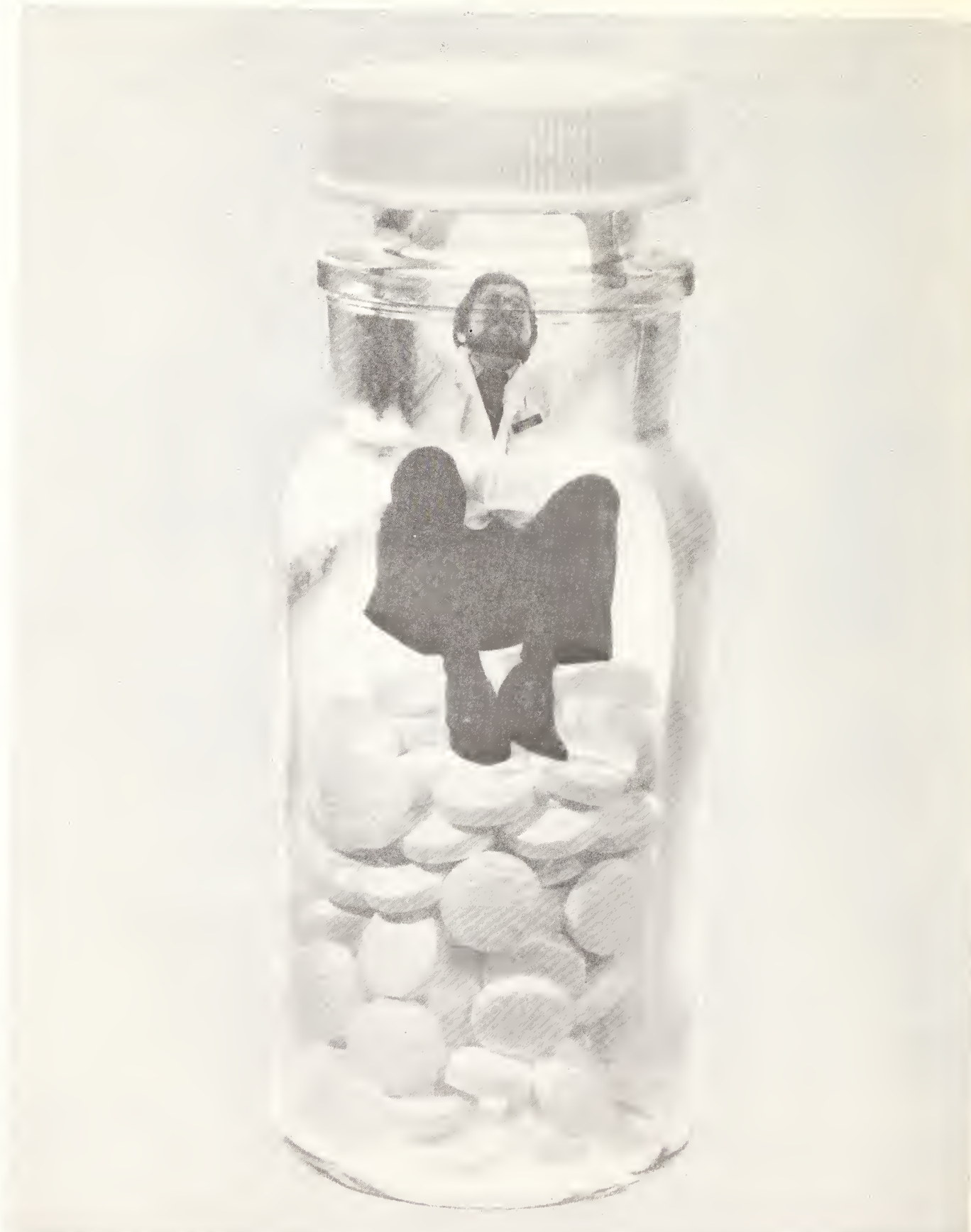
Poster comes in two sizes. Wall poster is 20″ x 23″. Standup poster is 11″ x 14″. Blank space at the bottom of the poster is for the address and telephone number for local information.

The copy on the poster reads:

The way to keep from having big health problems is to catch them while they're still small ones. If your children are eligible for Medicaid, we've got a program that will find and treat their health problems, if they have any, before they get too big. Why not check with your local welfare office and ask about the EPSDT program?

For your supply, write:
Editor,
Room 5327 MES Building,

Washington, D.C. 20201



Do Present Practices Bottle Up Pharmacists?

by Dr. Robert C. Johnson

It only stands to reason that if a Government-funded health care system is to provide for diagnosis of illness, it must also provide for treatment. I am talking not only about treatment through costly hospitalization and surgery, but about much less expensive treatment through drug therapy.

The report "Drug Coverage Under National Health Insurance: The Policy Option," sponsored by HEW, said this about drug therapy: "Of primary importance is the recognition that the use of drugs, although it represents only about one-tenth of the nation's enormous health care expenditures, is one of the most important and certainly the most widely used form of therapy.

- Each year, roughly half of all patients visiting a physician's office receive a prescription. On the average, each hospitalized patient gets eight prescriptions during his hospital stay.
- Even though drug expenditures are now up to many billions of dollars a year, the use of drugs is one of the least expensive types of treatment.
- When used rationally, drugs can minimize far more costly alternatives: needless and sometimes dangerous surgery, needless hospitalization, and needless office visits.
- It is all too evident that the misuse of drugs can injure or kill, but it is equally apparent that the harm caused by drugs is far outweighed by the benefits."

The first requirement of good drug coverage is that it should be broad enough to assure treatment of all common disorders. Further, drugs needed to treat rare conditions should be available after authorization.

In order to achieve this goal, it appears that a formulary approach—a list of drug products that are allowed to be dispensed—would be most acceptable, and the formulary should be consistent with current clinical judgments. This can be accomplished best through the use of a formulary task force or advisory committee consisting of clinical practitioners in both pharmacy and medicine.

The formulary should be structured to meet the definition of national prescribing set forth by the HEW Task Force on Prescription Drugs: "The right drug for the right patient in the right amounts and with due consideration of relative costs."

One example of this is the exclusion of irrational drug combinations and duplicate products such as those sometimes used in hypertension control. Another example is limiting the use of thiazide diuretics to only one from each of the three classes, based upon onset and duration of action.

Also, to meet the definition of rational drug use and cost containment, the formulary should provide for the inclusion of certain over-the-counter drugs, the most obvious being insulin, antacids, and analgesics.

Program costs can be reduced through the appropriate use of nonlegend drugs. The California Medi-Cal Program in Fiscal Year 1976 paid almost $7 million for 1.2 million prescriptions of APC with Codeine (½ gr) because no other non-narcotic analgesic was available in the formulary. If non-narcotic analgesics such as aspirin or acetaminophen had been available, this would have reduced program costs significantly.

A soundly administered program should also take into consideration the fact that self-medication will frequently fulfill a patient's needs, especially if the patient has access to health counseling. There are routine symptomatic conditions which can be treated with less costly over-the-counter drugs if patients are assisted in their self-diagnosis and can be counseled properly on the use of these drugs. This is particularly true with antacids, anti-diarrheals, cough and cold preparations, and analgesics.

There are many cases where aggravated conditions go untreated, leading to more critical episodes that require more costly physician attention and, at times, hospitalization.

Our present system of providing health care is less than optimal. What steps can be taken to improve this situation?

We have often heard the statement that the pharmacist is the most overeducated or under-utilized health professional. Health planners, Government officials, and others, while making this statement, have done very little to encourage greater use of the pharmacist's expertise in drug therapy. The pharmacist's role as a drug consultant would provide virtually unlimited potential for successful prevention of prescription drug misuse.

A recent study, conducted jointly by the California Medical and Hospital Associations, revealed that drugs were responsible in 18.8 percent of occurrences leading to compensable events, such as malpractice settlements. Most of these drug misuses occurred in outpatient settings.

With regard to pharmacist monitoring of patient drug therapy, it is important not to overlook the problem of medical malpractice or the necessity of physicians to utilize the assistance of pharmacists in avoiding potential adverse drug reactions.

Patient profiles

A patient profile, properly used,

Dr. Robert C. Johnson is a pharmacist and executive vice president of the California Pharmaceutical Association. This article is adapted from a speech presented at a recent conference of HCFA's Institute of Medicaid Management in Albuquerque.

provides the pharmacist with a complete drug history of the patient, including allergic reactions or other drug sensitivities or toxicities. It is indispensable in avoiding adverse drug reactions when the patient is receiving multiple prescriptions from one physician or a variety of physicians. Further, if the pharmacist encourages the patient to report over-the-counter drugs that he is taking, the pharmacist will be able to identify potentially dangerous interactions between prescribed and self-medicated therapies.

While some States—New Jersey, Maine, and Washington—have mandated the use of patient profiles through statutes or regulations, others have found that peer pressure or potential malpractice exposure is sufficient inducement, and this has resulted in a significant increase in profile usage by pharmacists.

The California Pharmaceutical Association has called for an amendment to the State Title XIX (Medi-Cal) regulations defining patient consultation and profiles as pharmaceutical services required under the program, with commensurate remuneration for such services. This action is indicative of the interest displayed throughout the profession in enabling the pharmacist to fulfill a more meaningful role in patient care.

With respect to the Medicaid Program, it is our contention that the appropriate use of pharmacists as members of the health team will result in reduction of hospital admissions, fewer physicians' visits, and elimination of unnecessary emergency room utilization.

Reimbursement systems

Now, with regard to reimbursement, most Medicaid Programs compensate for pharmaceutical services on the basis of a professional fee in addition to remuneration for drug product cost. The most widely used method of reimbursement for product cost is based on the average wholesale price (AWP). AWP is usually defined as either the average cost of a drug product through the drug wholesale distribution system or the price at which the drug is or should be generally obtainable—that is, if manufacturers and wholesalers would follow a uniform pricing system for all classes of purchasers. However, such is not always the case.

The advantages of AWP are that the price is easy to find in various price lists (i.e., *Red Book* or *Blue Book*) and can be easily programed into a computer system, thus facilitating administration.

The disadvantage of AWP is that it may be higher than the actual cost paid by the pharmacist, thus compensating some providers at grossly exaggerated reimbursement levels. And, there is no incentive for controlling manufacturing costs.

Another product reimbursement mechanism is the actual acquisition cost (AAC). The advantage of this system is that it fairly compensates all providers for their exact product costs, thereby eliminating arbitrary estimates. It controls inflated "100 price" vis-a-vis the usually purchased larger quantity package sizes, 500 or 1000.

The disadvantage of this system is that the actual cost is difficult to determine because of the vast pricing differentials at which drug products are sold. Thus, unlike AWP, there is no single acquisition cost which can be easily entered into a computer system.

A plan known as estimated acquisition cost (EAC), a departure from actual acquisition cost, was recently established by HEW. In this writer's opinion EAC provides no legitimate definable means of determining the amount other than somebody's guess. Since it is purely a fictitious price, generally without relevance to most drug purchases, it should be abandoned.

It is also this writer's belief, and that of others, that HEW and the states using the EAC system are clearly vulnerable to litigation for attempting to devise a plan for which there is no statutory authority or economic basis in the marketplace.

Permitting reimbursement at the federally-established maximum allowable cost (MAC) level is yet another control mechanism used to contain product cost. Maximum allowable cost is a drug product price established by the government, presumably with advice from members of the profession, at which a multiple-source drug is available to all purchasers.

The MAC concept had its origin in California where it is known by the acronym MAIC, Maximum Allowable Ingredient Cost. It has been in effect on a variety of multi-source drugs for a number of years and has had a cost-saving effect on the Medi-Cal budget. MAIC is generally supported by the profession. It can be universally administered and should be updated as market conditions change.

While on the subject of product costs, let me add that the prices paid for drugs must be those prices in force at the time the service is rendered. During Calendar Year 1976 Medi-Cal reported 5,073 drug price changes which resulted in cost increases of $2,526,000.

As for the professional component of the reimbursement system, HEW sets a fee rather than a percentage markup as the basis for compensation. One can determine from the language contained in the federal regulations that the intent is to pay usual, customary, and reasonable fees based upon current market data as determined from mandated fee studies. To date, however, it appears that states have made little effort to implement this aspect of the regulation.

Most states presently are reimbursing on an average statewide professional fee. Some of the states have not adjusted this fee to meet annual inflationary cost-of-living increases, thus creating an unparalleled economic hardship for many practitioners in our health delivery system.

Many pharmacists, in order to survive, have had to greatly escalate costs to their privately-paying patients in order to compensate for "underpayment" by the government. Thus, the burden of government underpayment frequently falls on the shoulders of those least able to pay, namely our senior citizens, the greatest users of drugs in the private-pay sector. Medicaid officials and legislative bodies must take prompt action to relieve this situation.

In further considering the "average professional fee" currently in vogue in most states, it is important to recognize the problem it presents: If a professional fee is in fact "average," it will by definition over-compensate about half of the providers and under-compensate the other half.

When analyzing the cost studies that have been conducted in some states, it is evident that there are wide variations in fees among pharmacists, and this cannot be adequately reflected in an average fee. The range in Florida, for example, was $1.18 to $4.02, in Colorado $1.12 to $5.42, and in California $0.77 to $6.25.

It is this writer's belief that present average fees must be replaced with fees based on true operating costs and with provision for reasonable returns on investments. This will resolve any inequities of the average fee and will provide an incentive for supplying essential professional services.

Drug utilization review

Lately there has been a great deal of talk about drug utilization review. Speaker after speaker at the National Center for Health Services Research Conference in Washington recently recommended both the need for and the value of Drug Utilization Reviews. Thus far the concept exists only in the minds of health planners and progressive program administrators, although a vast number of state programs subscribe to this approach to curb costs and over-utilization.

Other attempts at review are failing due to inadequate funding and staffing of the Drug Utilization Review Committee, and because adequate procedural guidelines have not been developed.

In an effort to assist the California Department of Health in implementing a review system, the California Pharmaceutical Association, in consultation with the department, developed the following guidelines for the committee:

- identify local standards of practice
- identify criteria for monitoring adherence to these standards
- educate practitioners
- refer abuses to program administrators if education does not alter practice

Two studies of committee activities in California indicate that the education of 11 pharmacists caused them to change their practices, resulting in an annual savings of $200,000. It can readily be seen that immense savings will be achieved if this concept is universally applied. Of even greater importance is the improved patient care through more rational prescribing.

Under some Medicaid programs, long term care patients are provided only the same drug benefits as ambulatory patients. Thus, many needed drugs, especially injectables, are not readily available and can be obtained only through a prior approval system. This situation is clearly not in the best interests of the patients and increases the program's administrative costs.

While most Title XIX programs strictly enforce the Federal provisions and require pharmacists to perform on-site review of charts of long term care patients, very few are paying for this service. California, New Jersey, and Massachusetts are noted exceptions.

In California the person required to provide the service is not the person directly paid for it. Instead, compensation is made through the nursing home with no assurance that it is, in fact, being passed on to the pharmacist. Such indirect payment greatly increases the potential for kickbacks. In such situations there is incentive to reduce the level of service to only minimal compliance, thus negating the intent of the law. Indirect payment is satisfactory only if the state agency assumes the responsibility to ascertain that compensation is quickly passed on to the pharmacist.

Claims processing

Of significant importance is the mechanism for claims processing. If one can't ensure the prompt and rational payment of claims, the integrity of the program will certainly suffer.

Lost claims and the expense of maintaining accounts receivable amount to significant overhead costs which few pharmacies can afford.

To give you an example of the magnitude of this situation, drug expenditures in California in Fiscal Year 1977 were $144 million or $12 million per month. If claims are paid in 30 days, the 4,300 pharmacies in the state, excluding hospitals, would have an average accounts receivable of $2,800. Not many of us can sustain such a capital outlay, so payment must be prompt.

We must also strive to simplify the process of claims submission. For example, plastic ID cards might be issued to eligible persons to increase accuracy of claims data and to decrease provider processing time. Such cards could be validated for longer periods, with confirmation of eligibility provided to beneficiaries on a monthly or bi-monthly basis.

Another means of facilitating

claims processing and reducing program costs is tape-to-tape transfer of billing claims. At least seven states—Michigan, Texas, Ohio, New Jersey, Indiana, Maryland, and Massachusetts—currently accept claims processing in this manner. Perhaps all states could provide this mechanism. It increases the accuracy of claims data and decreases administrative costs. Such savings could be shared with the pharmacist, who may experience an increase in billing costs in order to provide computer-readable input. Some states are, in fact, sharing cost savings with pharmacists who are using computer billing systems.

Medicaid is now 12 years old and little has been undertaken to determine the effectiveness of the care it pays for, or to evaluate methods for improving care, or to design rational approaches to curbing program costs. Numerous other questions could be answered just by taking advantage of the wealth of data that is obtainable in the Title XIX programs.

Control methods

The more complicated the control, the more difficult to ensure provider compliance.

One control that has been used with some degree of effectiveness is the drug formulary. A formulary, if it is complete enough to provide the ready availability of drugs to treat common disorders in a manner consistent with current clinical judgment, can indeed be useful in containing program costs.

It should be noted, however, that the content of the formulary should be determined in consultation with pharmacists and medical practitioners. This would help to assure appropriate clinical composition as well as professional acceptability. Furthermore, it should be reviewed and updated on a regular and timely basis. There also should be provision for exceptions, based upon medical necessity. This might best be accomplished through a prior authorization mechanism, preferably at the local drug utilization review committee level.

Formularies might be eliminated, however, under the following conditions:

- More rational prescribing by medical practitioners
- More fully implemented drug utilization review procedure
- Greater incentive for selecting drug products of low cost but consistent with quality

Although these conditions are administratively less expensive than formulary utilization, none is in effect at this time. Until they are, a formulary is a reasonable compromise.

Experience with a restricted formulary system has created reason to believe that it is an effective way of greatly reducing or eliminating expenditures for ineffective drugs. It provides a means for encouraging rational prescribing and for eliminating expenditures for excessively expensive drugs when lower cost medicinals are available in the same range of therapeutic classification.

Another form of control is the dispensing of minimum quantities. A 1-month supply of what is truly a chronic maintenance medication is generally supported by the profession. There is dissatisfaction, however, when ingredient costs are not adequately compensated. In California, for example, payment for psychotropic drugs like Prolixin is based upon the direct price of packages of 500.

The integrity of the program can suffer and patient care can be unnecessarily interfered with, when program administrators insist on focusing controls such as minimum quantity limitations on all drugs: three in 75-day refill limitations, a monthly limitation on the number of prescriptions that can be written, and other controls.

Another control unsuccessfully attempted is what has been termed in California as a Code One restriction: Limiting the use of certain formulary drugs to specified conditions. Such limitations are frequently arbitrary, and it is nearly impossible to comply with most of them. The California Department of Health recognizes the problem and is in the process of eliminating most Code Ones which rely on data not readily available to the pharmacist (e.g., diagnosis).

Patient cost sharing is another mechanism that has been attempted in controlling drug utilization. Co-payment was tried in California for 2 years but was discarded when no significant benefit could be demonstrated. If co-payments are high enough to reduce utilization, they are probably too high for the income levels of many Medicaid patients. If co-payment is used, there is no effective control unless provider collection is mandated.

A final comment on control: providers most likely tend to support legitimate audit procedures when there is reason to believe that a provider is abusing the program. Providers should, however, be given detailed guidelines as to how the audit will be conducted, what specific types of problems or potential abuses will be investigated, and what corresponding actions will be taken. Providers who are audited should be afforded the opportunity to justify their actions and to provide any necessary documentation prior to the conclusion of the audit. ■

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RISING
COSTS

Blue Shield Plan Fights Inflation by Clamping Ceiling on Fee Increases.

by Thomas H. Girard

In an attempt to contain medical costs, Surgical Care-Blue Shield has placed a 5-percent ceiling on all increases in physician fees for a 12-month period. This ceiling, which also applies to dental and podiatric services, is expected to save $3 to $4 million during this period.

Surgical Care's aggressive action to limit the increase in prevailing physician fees is believed to be unprecedented in the voluntary health insurance market. Thus far, the ceiling appears to be achieving its objective.

The ceiling, which went into effect on June 1, was unanimously approved by the plan's board of directors. It will remain in effect until May 31, 1979. At that time, Surgical Care will reevaluate the economic climate before setting further limits. The anti-inflation initiative is being undertaken in close cooperation with the medical profession throughout Wisconsin.

Approximately 95 percent of Surgical Care's contracts, covering some 1.3 million participants, provides benefits on the basis of "usual, customary, and reasonable charges." Subscribers are not required to pay physicians' fees which exceed the plan's recognized payment allowances. In fulfilling its commitment to "hold the subscriber harmless" from excessive physician fees, Surgical Care is willing to defend its level of payments in court if necessary—that is, if a physician elects to initiate a collection action. The plan also pays for court costs, legal costs, etc., which might be incurred in defending its payment.

Thomas H. Girard is president and chief executive officer of Surgical Care-Blue Shield in Milwaukee.

The 5 percent ceiling on prevailing fees was not an isolated effort to help contain medical costs. Quite the contrary. Since 1966, Surgical Care-Blue Shield, in cooperation with the medical profession in Wisconsin, has successfully limited increases in prevailing physicians' fees to the approximate level of increase in the national Consumer Price Index for all items. Thus, the 5 percent ceiling represents an extension of the plan's long-standing policy to keep the lid on physician fee increases.

The success of Surgical Care's efforts to restrain physician fee increases probably would not have been possible were it not for the support and cooperation of the medical community.

Dr. Derward Lepley, vice chairman of the plan's board of directors, acknowledges the responsibility of physicians in seizing the initiative in cost containment programs. "As physicians, we hold primary responsibility for providing quality medical care to the public," said Dr. Lepley. "We need to exhibit leadership among all segments of health care if we are to attain the necessary goal of cost containment. However, voluntary fee restraint is not the sole solution to the medical cost problem."

While Surgical Care did not seek formal endorsement for its program from either the Medical Society of Milwaukee County or the State Medical Society of Wisconsin, it did hold briefing sessions with officials of both associations prior to announcing the 5-percent ceiling. Plan officials also held informative discussions with representatives of various medical specialty associations and with the respective chairmen of the plan's physician insurance advisory committees throughout Wisconsin. Those discussions were invaluable in gaining widespread physician support for the program.

"The price of physicians' services is only one element affecting overall medical costs," Dr. Lepley said. "New and costly medical equipment, rising labor costs, demands for complete coverage and insurance benefits, expanding use of outpatient and emergency facilities, and the unnecessary duplication of programs and services all contribute to the current cost spiral.

"Limiting physician reimbursement on a voluntary basis deals with only one aspect of the cost problem, but it is a positive step that must be taken. The ceiling on prevailing physician fee increases was imposed by Surgical Care, in part, to publicly demonstrate that cost containment can be achieved by the private sector without government intervention," Dr. Lepley said, "Widespread acclaim for the program from Wisconsin employers, elected officials, and the news media have reinforced our contention that health care cost containment is a major issue of concern to the people of Wisconsin. Our program appears to be right on target."

The "prevailing" fee levels or maximum fee levels recognized by Surgical Care-Blue Shield are designed to pay in full, up to 90 percent of all charges for covered services rendered to the plan's subscribers. Charges which exceed the plan's usual, customary, and reasonable level are routinely challenged; and in 1977,

Publications

Please address all inquiries and requests for publications and films to the addresses in the listings. Items for review should be sent to Theresa Williams in care of this magazine.

A comparison of U.S. health care within five volumes. Springer Publishing Company, Dept. H107, 200 Park Avenue South, New York 10003.

Volume I: *Worldwide Overview Of Health and Disease.* Steven C. Joseph, M.D., M.P.H.; Dieter Koch-Weser, M.D., Ph.D.; and Ned Wallace, M.D., M.P.H. $5.00.

Subjects include health problems of the rich and poor countries, worldwide epidemiologic patterns, the health of the world's children, development and allocation of health resources and international cooperation in health.

Volume II: *Assessment of Health Status and Needs.* Timothy D. Baker, M.D., M.P.H. $4.00.

Subjects include assessment of health problems and resources: Concepts, regional differences in health status and resources, the quality and appraisal of data and sources of data.

Volume III: *Ecologic Determinants of Health Problems.* Michael M. Stewart, M.D., M.P.H.; Richard H. Morrow, Jr, M.D.; Allan G. Rosefield, M.D., F.A.C.O.G.; and Robert M. Suskind, M.D. $7.00

Subjects include general ecological considerations, health impact of industrialization and urbanization, bacterial/viral diseases, population, protein calorie malnutrition and nutritional anemias.

Volume IV: *Sociocultural Influences on Health and Health Care.* Ray H. Elling, Ph.D. $5.00

Subjects include social forces that mold the individual's self concept, the group image, economic forces, political forces, and forces for equity and health.

Volume V: *Systems of Health Care.* Milton I. Roemer, M.D., M.P.H. $7.00

Surgical Care's frugal administration of its usual, customary and reasonable program saved plan subscribers an estimated $2.6 million.

Since Surgical Care does not use "participating agreements" with physicians, its reimbursement criteria impact affects nearly all physicians in the state. The "hold harmless" concept applies to all covered services as long as there has been no agreement between the subscriber and the physician about the fee prior to the services being rendered.

Surgical Care's cost containment record is especially noteworthy in view of recent questions being asked nationally about the propriety of physicians serving on the boards of Blue Shield plans. The Surgical Care-Blue Shield board consists of 16 members, of whom nine are physicians. Since 1971, Surgical Care has methodically expanded its board to include non-physician members. It is the plan's intention to eventually arrive at a board composition of 50 percent physicians and 50 percent non-physician members. All board members serve without compensation as do all physicians serving on the plan's various insurance advisory committees.

The genesis of Surgical Care's ceiling on prevailing physician fee increases is steeped in a history of initiatives to contain medical costs. In 1961 Surgical Care was among the first Blue Shield Plans in the country to launch a major medical contract, a program designed to provide a wide range of benefits and to make use of important cost saving features such as coinsurance and deductibles.

Also in the early 1960s Surgical Care revised its marketing strategy and encouraged the use of outpatient benefits as alternatives to costly inpatient hospital care. In 1963 the plan endorsed the concept of coordinated home care and added benefits for home care to all of its contracts.

In 1971 the first prepaid group practice program in Wisconsin was launched at Milwaukee's Northpoint Medical Clinic with Surgical Care acting as a co-sponsor. A second program at Marshfield, Wisconsin, began operation later in the same year. The two highly successful health maintenance organizations, with a present enrollment of 65,000 persons, were among the first prepaid group practice programs in the country to be sponsored by either Blue Cross or Blue Shield plans.

Another example of Surgical Care's long-standing commitment to cost containment was demonstrated in 1975 when it completed an extensive study of the four most common open-heart procedures. On the basis of its review, Surgical Care determined that the complexity and difficulty of open-heart surgery had decreased over the years. At the same time, physician expertise continued to improve.

As a result of these findings, officials of Surgical Care, as well as members of a special cardiac surgery subcommittee of physicians, did not feel that fee increases were appropriate for the four open-heart surgery procedures. Their recommendations resulted in a freeze being placed on cardiac surgical fees from 1975 through 1977.

During the past year, Surgical Care expanded its utilization review efforts to help identify questionable physician utilization practices within the medical community. The plan also has adopted the "medical necessity program," initiated by the National Blue Shield Association, which identified some 42 medical, surgical, and diagnostic procedures felt to be of limited value to the patient. Payment for these procedures is withheld by Surgical Care unless there is substantiating information submitted by the physician indicating the necessity and value of the procedure.

The diversified cost containment programs initiated by the plan demonstrate that the private sector is fully capable, able, and committed to a reasonable and aggressive approach to contain costs currently plaguing the health care industry. These efforts can be most effective when they are undertaken on a cooperative basis with private industry and the medical community working together as they have done successfully in Wisconsin. ■

State and National News

Continued on page 23

HCFA aids young mothers in caring for infants.

HCFA's Early Periodic Screening, Diagnosis, and Treatment Program has awarded $345,636 to the Maryland State Department of Health and Mental Hygiene to support the first year of a health and family service project in Baltimore for teenage mothers and their children.

Operated by the Johns Hopkins Center for Teenage Mothers and Their Infants, the project will provide comprehensive health care for the mother during pregnancy and for the mother and child in the postnatal period. Medical services will be provided for 2 years, supplemented by programs for parents on child development, family life, family planning, nutrition, and coping skills needed to develop social maturity. Mothers also will be helped to identify their educational and vocational needs, and to return to school.

Teenage mothers and their infants are particularly vulnerable to physical complications of pregnancy, premature birth, and higher rates of infant mortality. The project is expected to provide the range of health and social services necessary to help prevent unwanted future pregnancies and help young families free themselves from dependency on welfare.

Disease classification to be required.

Use of a new international system for classifying diseases, employed in compiling health care statistics in hospitals and other institutions, will be required by HCFA's Medicare program, Professional Standards Review Organizations, and the Cooperative Health Statistics System beginning in January.

Adoption of the system, according to HCFA officials, will eliminate problems of duplication that now occur because two reporting methods are used.

Called the International Classification of Diseases, Ninth Revision, Clinical Modification, the system contains more than 10,000 five-digit diagnostic codes and more than 3,000 four-digit medical procedure codes. It has been endorsed by the U.S. National Committee on Vital and Health Statistics and other major health organization.

The classification system, contained in three volumes, is available from the American Hospital Association, Order and Processing Department, 840 North Lake Shore Drive, Chicago 60611. Prepaid price of the hardbound edition is $52.50; softbound, $45.50. Postpaid prices are $59.50 and $52.50 respectively.

Calendar

October 29—November 1—American Association of Homes for the Aging, annual conference, Cincinnati. For information, contact AAHA, 1050 17th Street, N.W., Washington, D.C. 20036 (202-296-5960).

October 25-26—American Group Practice Association, annual meeting, New Orleans.

Carolyn Boone Lewis has been named to the Provider Reimbursement Review Board, which deals with Medicare payment issues. Lewis has been with the Securities and Exchange Commission since 1962, most recently as a branch chief in its division of investment management.

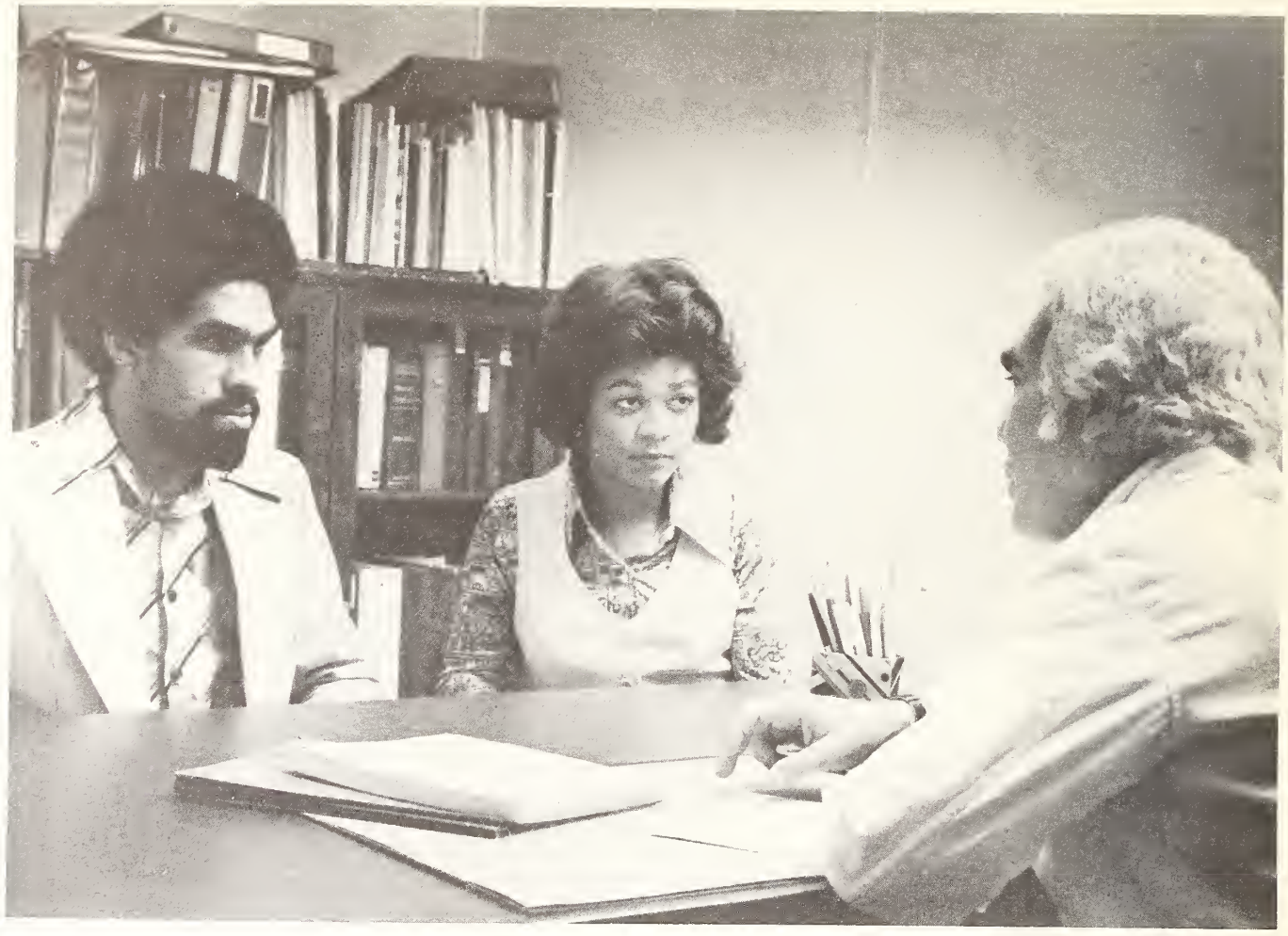
Protect Your Child

A brief, simply written folder urges young mothers and mothers-to-be to call their local social services office for assistance in immunizing their children.

The folder describes the seven preventable childhood diseases and the type and schedule of preventive dosages.

A blank space on rear panel of the folder can accommodate a local phone number and address. For a supply of free copies write:

Protect Your Child
Room 2114
MES Bldg.
330 C. St. SW
Washington, D.C. 20201



Are you sure you know what family planning is <u>all</u> about?

If you think family planning means taking measures to prevent unwanted pregnancies . . . you're only partially right. Certainly, family planning does offer ways to have children only when you want them . . . can afford them the best . . . and love them the most.

But did you know that it also means:

- making sure you're healthy before, during, and after pregnancy
- counseling and helping solve fertility problems for couples who want to have children but can't
- counseling men on male responsibility for birth control
- counseling young people about their problems and how having a baby can affect their health and their lives

So be sure you know ALL about family planning . . . <u>it means more than you may have thought.</u>

All these services are available from the family planning clinic in your community, your local health department, or your own physician.

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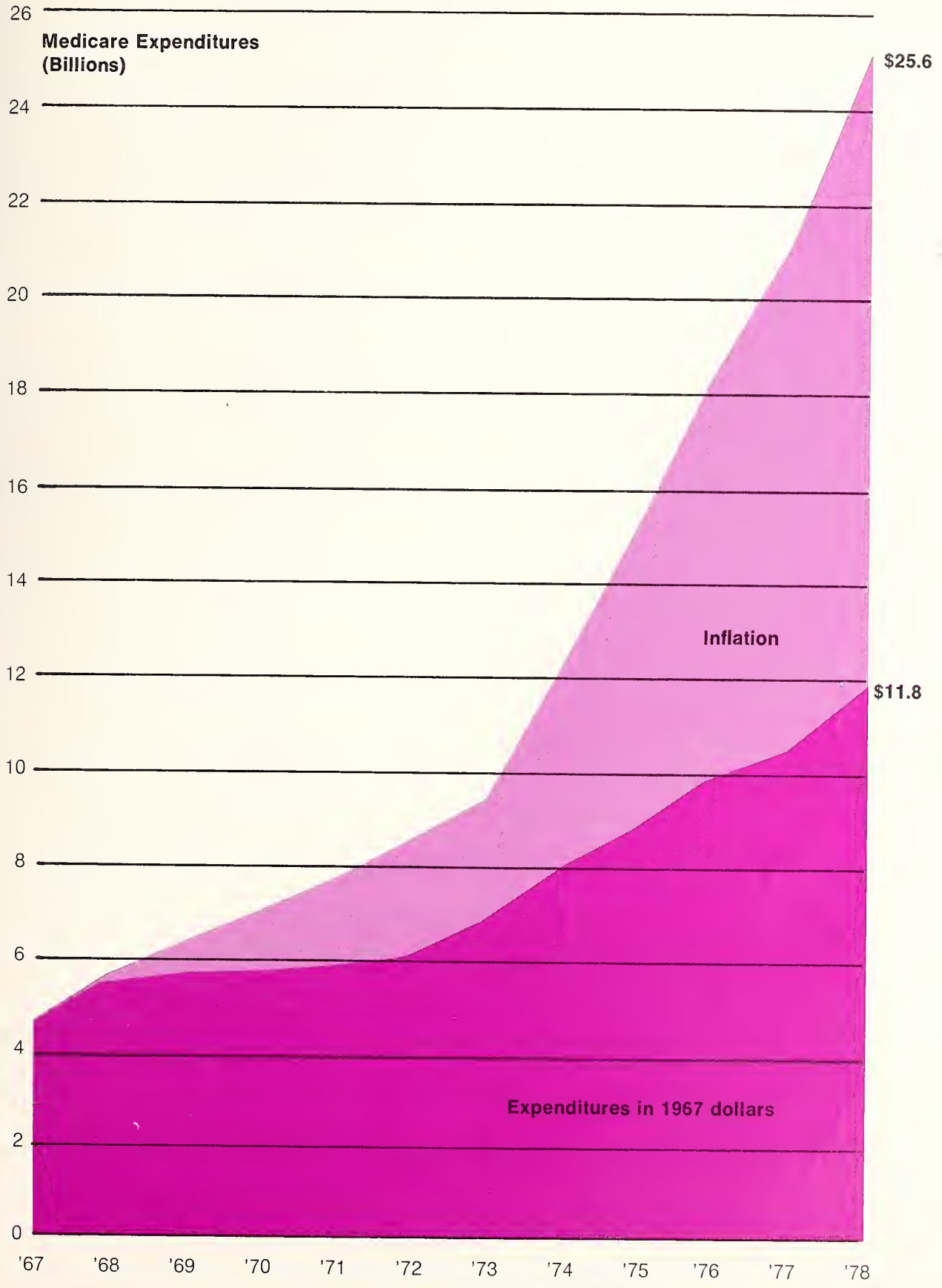
Public Health Service

Medicare Benefit Expenditures for Calendar Years 1967-1978.



Source: Bureau of Labor Statistics, the 1978 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. 1978 figures are projected.

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